

UTAH STATE BULLETIN

OFFICIAL NOTICES OF UTAH STATE GOVERNMENT
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Nancy L. Lancaster, Editor

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Inquiries concerning administrative rules or other contents of the *Bulletin* may be addressed to the responsible agency or to: Division of Administrative Rules, 4120 State Office Building, Salt Lake City, Utah 84114, telephone (801) 538-3218, FAX (801) 538-1773. To view rules information, and on-line versions of the division's publications, visit: <http://www.rules.utah.gov/>

The information in this *Bulletin* is summarized in the *Utah State Digest (Digest)*. The *Digest* is available by E-mail or over the Internet. Visit <http://www.rules.utah.gov/publicat/digest.htm> for additional information.

Division of Administrative Rules, Salt Lake City 84114

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SPECIAL NOTICES

Governor's Executive Order 2005-0012: Creating the Outdoor Recreation Economic Ecosystem Task Force

EXECUTIVE ORDER

Creating the Outdoor Recreation Economic Ecosystem Task Force

WHEREAS, Utah has numerous and varied natural attractions, features, and landscapes that set it apart as a premier destination for outdoor recreation opportunities and make Utah a world-renowned outdoor recreation capital;

WHEREAS, Utah is home to numerous quality manufacturers, retailers, and outfitters of outdoor recreation equipment and products that serve a worldwide market;

WHEREAS, Utahns and visitors to Utah have a high level of interest in outdoor recreation;

WHEREAS, the State of Utah is interested in ensuring that a full spectrum of recreation opportunities is available to the public;

WHEREAS, the outdoor recreation industry is an increasingly important component of Utah's economy;

WHEREAS, it is in Utah's interest to develop and support a strong outdoor recreation economy that benefits not only the outdoor recreation businesses in Utah, but also Utah's economy generally, as well as Utah's natural heritage;

WHEREAS, appropriate management and preservation of Utah's outstanding natural areas is essential to the continued vitality of the outdoor recreation experience;

WHEREAS, preserving appropriate access to premier outdoor recreation destinations is important to the viability of the outdoor recreation experience;

WHEREAS, wilderness, wildlands, and other natural settings are an important component of the outdoor recreation economy and, therefore, can possess economic value for the state;

NOW, THEREFORE, I, Jon M. Huntsman, Jr., Governor of the State of Utah, by virtue of the authority vested in me by the laws and the constitution of the state, hereby order the following:

1. There is created the Outdoor Recreation Economic Ecosystem Task Force.
2. This Task Force, executive order, and the provisions thereof constitute phase I of an ongoing initiative, and it is expected that phase I shall be completed, and this executive order supplanted or revoked, on or before July 1, 2007.
3. The Task Force shall:
 - a. identify Utah's premier outdoor recreation destinations and natural assets;
 - i. identify the state's "recreation gems;"
 - ii. identify the state's rural "recreation economic ecosystems" or areas of the state with a focus on public recreation land opportunities, wildlands, cultural and heritage resources which deserve preservation, recognition and coordinated management;
 - b. identify the protection and or management needs of those "recreation gems" and "recreation ecosystems;"
 - c. work with local, state, and federal governments and agencies to facilitate and develop sustainable protection and proper management of those "recreation gems" and "recreation ecosystems;"
 - d. work with local, state, and federal governments and the tourism industry to promote local recreation assets and outdoor recreation to the benefit of local communities and rural economies across Utah;

e. identify information sources and technologies including geographic information systems that will contribute to identifying and advertising outdoor recreation opportunities.

4. The task force shall be appointed by the Governor and shall include one or more representatives from the following, for a total of 15 to 18 voting members and three non-voting members:

- a. four to six members from state agencies, including:
 - i. the Director of the Governor's Office of Planning and Budget or designee;
 - ii. the Executive Director of the Department of Natural Resources or designee;
 - iii. the Coordinator of the Public Lands Policy Coordinating Office;
 - iv. the Director of the Division of Travel and Tourism or designee;
- b. four to six rural county commissioners or members of county councils; and
- c. four to six Utah outdoor recreation manufacturers, retailers, and other industry professionals in Utah.
- d. three members from the tourism industry in Utah including:
 - i. two representatives from the tourism promotion/marketing industry;
 - ii. one representative from the tourism academic field;
- d. three non-voting members from federal agencies including:
 - i. a representative from the United States Forest Service;
 - ii. a representative from the Bureau of Land Management;
 - iii. a representative from the National Park Service;

5. Members of the task force shall serve without per diem and expenses.

6. It is anticipated that all members shall serve terms concurrent with phase I, ending on or before July 1, 2007.

7. The terms of the state officials shall correspond to their terms of service in the relevant assignment. Members who are county officers may not serve beyond the expiration of their term in county office.

8. The Governor shall appoint the chair of the task force.

9. Staff support shall be supplied by the Governor's Office of Planning and Budget.

10. A majority of the task force constitutes a quorum for voting purposes, and all actions shall be by majority vote of the quorum in attendance at a meeting.

11. The task force may meet as often as necessary to perform its duties, and shall meet at least quarterly.

12. The state agencies represented on the task force, as well as other state agencies that may be involved in specific task force issues shall work collaboratively and productively to achieve the goals of this order.

13. The Governor's Office of Planning and Budget, in collaboration with other state agencies as necessary, shall identify the land management and ownership status currently in place for the premier outdoor recreation destinations and natural assets identified by the task force under Paragraph 2.b, for subsequent use by the Governor in seeking any modification that may be appropriate to preserve or enhance those destinations or assets.

14. This order shall remain in effect until revoked or supplanted by executive order.

IN WITNESS WHEREOF, I have hereunto set my hand and cause to be affixed the Great Seal of the State of Utah. Done in Salt Lake City, Utah, this 10th day of June, 2005.

(State Seal)

JON HUNTSMAN JR.
Governor

ATTEST:

GARY HERBERT
Lieutenant Governor

2005/0012

Governor's Executive Order 2005-0013: State of Emergency

EXECUTIVE ORDER

State of Emergency

WHEREAS, heavy winter snowpack has accumulated in the mountains throughout Utah, creating a potential for heavy spring runoff;

WHEREAS, unusually heavy spring rainstorms compounded the problems, causing widespread flooding, damaging erosion, and several major landslides;

WHEREAS, sustained flood fighting efforts occurred between January 8 and June 13, 2005, and are ongoing;

WHEREAS, substantial State assistance was provided to Tooele, Cache, Box Elder, Utah, Wasatch, Kane, Morgan, and Beaver Counties;

WHEREAS, substantial sustained State assistance was provided to Sevier, Iron and Uintah Counties, and to the Ute Indian Reservation;

WHEREAS, the State Legislature passed House Bill 240, providing low interest disaster loans of up to \$25 million dollars to Washington County, at the onset of the flooding;

WHEREAS, State assistance has come from the Utah Department of Transportation, the Utah National Guard, the Department of Public Safety and the Division of Emergency Services, the Utah Department of Health, the Utah Department of Environmental Quality, the Utah Department of Natural Resources; in the form of road repairs, landslide technical assistance and monitoring, potable water hauling, provision of emergency access to flood stricken areas, diversion of floodwaters, and the provision of equipment and supplies for emergency protective measures;

NOW THEREFORE, I, Jon M. Huntsman, Jr., Governor of the State of Utah by virtue of the power vested in me by the constitution and the laws of the State of Utah, do hereby order that:

It is found, determined and declared that a "State of Emergency" exists statewide due to the spring snowmelt and rainfall floods, requiring aid, assistance and relief available pursuant to the provisions of state statutes, and the State Emergency Operations Plan, which is hereby activated.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Utah this 17th day of June, 2005.

(State Seal)

Jon M. Huntsman, Jr.
Governor

ATTEST:

Gary R. Herbert
Lieutenant Governor

2005/0013

End of the Special Notices Section

NOTICES OF PROPOSED RULES

A state agency may file a PROPOSED RULE when it determines the need for a new rule, a substantive change to an existing rule, or a repeal of an existing rule. Filings received between June 16, 2005, 12:00 a.m., and July 1, 2005, 11:59 p.m. are included in this, the July 15, 2005, issue of the *Utah State Bulletin*.

In this publication, each PROPOSED RULE is preceded by a RULE ANALYSIS. This analysis provides summary information about the PROPOSED RULE including the name of a contact person, anticipated cost impact of the rule, and legal cross-references.

Following the RULE ANALYSIS, the text of the PROPOSED RULE is usually printed. New rules or additions made to existing rules are underlined (e.g., example). Deletions made to existing rules are struck out with brackets surrounding them (e.g., [~~example~~]). Rules being repealed are completely struck out. A row of dots in the text (.) indicates that unaffected text was removed to conserve space. If a PROPOSED RULE is too long to print, the Division of Administrative Rules will include only the RULE ANALYSIS. A copy of each rule that is too long to print is available from the filing agency or from the Division of Administrative Rules.

The law requires that an agency accept public comment on PROPOSED RULES published in this issue of the *Utah State Bulletin* until at least August 15, 2005. The agency may accept comment beyond this date and will list the last day the agency will accept comment in the RULE ANALYSIS. The agency may also hold public hearings. Additionally, citizens or organizations may request the agency to hold a hearing on a specific PROPOSED RULE. Section 63-46a-5 (1987) requires that a hearing request be received "in writing not more than 15 days after the publication date of the PROPOSED RULE."

From the end of the public comment period through November 12, 2005, the agency may notify the Division of Administrative Rules that it wants to make the PROPOSED RULE effective. The agency sets the effective date. The date may be no fewer than 31 days nor more than 120 days after the publication date of this issue of the *Utah State Bulletin*. Alternatively, the agency may file a CHANGE IN PROPOSED RULE in response to comments received. If the Division of Administrative Rules does not receive a NOTICE OF EFFECTIVE DATE or a CHANGE IN PROPOSED RULE, the PROPOSED RULE filing lapses and the agency must start the process over.

The public, interest groups, and governmental agencies are invited to review and comment on PROPOSED RULES. *Comment may be directed to the contact person identified on the RULE ANALYSIS for each rule.*

PROPOSED RULES are governed by *Utah Code* Section 63-46a-4 (2001); and *Utah Administrative Code* Rule R15-2, and Sections R15-4-3, R15-4-4, R15-4-5, R15-4-9, and R15-4-10.

The Proposed Rules Begin on the Following Page.

Commerce, Consumer Protection
R152-39
 Child Protection Registry Rules

NOTICE OF PROPOSED RULE

(New Rule)

DAR FILE No.: 28058

FILED: 06/30/2005, 16:12

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: A new statute, Child Protection Registry, Utah Code Title 13, Chapter 39, went into effect on July 1, 2005, and requires administrative rules for its implementation. This legislation was enacted through H.B. 165 (2004 General Session). (DAR NOTE: H.B. 165 is found at UT L 2004 Ch 338, and was effective 07/01/2005.)

SUMMARY OF THE RULE OR CHANGE: The rule implements procedures by which a person may register a contact point with the registry, and by which a marketer may verify compliance with the registry.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 13, Chapter 39

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: Marketers will pay a \$0.005 fee per e-mail checked against the registry. Four-fifths of that fee will go to the provider, and one-fifth of that fee will go into the Commerce Service Fund.

❖ LOCAL GOVERNMENTS: Local governments are not directly involved with enforcement of this rule, or its enabling legislation. Local governments also will not be involved with compliance. However, the legislation carries potential criminal penalties, and local law enforcement agencies may choose to engage in enforcement activities.

❖ OTHER PERSONS: Marketers will pay a \$0.005 fee per e-mail checked against the registry. Four-fifths of that fee will go to the provider, and one-fifth of that fee will go into the Commerce Service Fund.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Marketers will pay a \$0.005 fee per e-mail checked against the registry. Four-fifths of that fee will go to the provider, and one-fifth of that fee will go into the Commerce Service Fund.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: As directed by the Legislature, marketers who send e-mails that advertise a product or service that a minor is prohibited by law from purchasing, or that contain or advertise material that is harmful to minors, will pay a fee to enable them to remove registered e-mail addresses from their mailing lists.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

COMMERCE
 CONSUMER PROTECTION

HEBER M WELLS BLDG
 160 E 300 S
 SALT LAKE CITY UT 84111-2316, or
 at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Thad LeVar at the above address, by phone at 801-530-6929, by FAX at 801-530-6001, or by Internet E-mail at tlevar@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: Francine Giani, Director

R152. Commerce, Consumer Protection.
R152-39. Child Protection Registry Rules.
R152-39-1. Authority and Purpose.

Pursuant to Utah Code Section 13-39-203, these rules (R152-39) are intended to establish the procedures under which:

- (1) a person may register a contact point with the registry; and
- (2) a marketer may verify compliance with the registry.

R152-39-2. Definitions.

As used in these rules (R152-39):

- (1) "Contact point" is as defined in Utah Code Section 13-39-102.
- (2) "Division" is as defined in Utah Code Section 13-39-102.
- (3) "Marketer" means a person described in Utah Code Section 13-39-201(4).
- (4) "Provider" means the third party with whom the Division has contracted, pursuant to Utah Code Section 13-39-201(1)(b), to establish and secure the registry.
- (5) "Registry" is as defined in Utah Code Section 13-39-102.

R152-39-3. Information Required to Register.

(1) A person desiring to register an email address with the registry shall provide the following information to the provider:

- (a) the email address the person desires to register;
- (b) an affirmation that a minor has access to the email address;
- (c) an affirmation that the minor who has access to the email address is a Utah resident; and
- (d) an affirmation that the person registering the email address is a parent or guardian of the minor who has access to the email address.

(2) An email address may not become a part of the registry until:

- (a) the provider sends an email to the email address; and
- (b) the provider receives a response from the email described in R152-393(2)(a) verifying the person's intention to register the email address.

(3) A school or institution desiring to register a domain name shall provide verification to the provider that:

- (a) the school or institution primarily serves minors; and
- (b) the school or institution owns the domain name being registered.

R152-39-4. Information Required to Verify Compliance.

A marketer desiring to verify compliance with the registry shall provide the following information to the provider before the provider compares the marketer's email list against the registry:

- (1) the name, address, and telephone number of the marketer;
- (2) the specific legal nature and corporate status of the marketer;
- (3) the name, address, and telephone number of a natural person who consents to service of process for the marketer; and
- (4) an affirmation that the person described in R152-39-4(3) understands that improper use of information obtained from the registry is a second degree felony.

R152-39-5. Compliance.

(1) After a marketer has complied with R152-39-4 and paid the fee established by the Division under Section 13-39-201(4)(b), the marketer may submit the marketer's email list to the provider according to the privacy and security measures implemented by the provider.

(2) After a marketer has complied with R152-39-5(1), the provider shall, according to the privacy and security measures implemented by the provider, inform the marketer of the email addresses from the marketer's email list that are contained in the registry.

KEY: consumer protection, e-mail, minors, advertising
2005
13-39



Commerce, Real Estate
R162-9-2
Education Providers

NOTICE OF PROPOSED RULE

(Amendment)

DAR FILE NO.: 28059

FILED: 06/30/2005, 16:55

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Division of Real Estate has had a problem with an education provider who failed to obtain a certification from the Division that a certain course could be offered to real estate agents for continuing education credit, and then told the students to apply individually to the Division after the fact for continuing education credit. The rule is revised to prevent this type of abuse of students by continuing education providers. The Division wishes to offer a streamlined course certification procedure to those course providers who have standards in place for development of their courses and who have been certified for continuing education purposes in other states while still insuring that the course offerings meet quality standards, and that the fee that the out-of-state providers pay is equal to the certification fees paid by in-state providers.

SUMMARY OF THE RULE OR CHANGE: The rule is revised to explicitly state that a course provider marketing to Utah licensees must obtain certification of a course from the

Division prior to offering the course to students for continuing education credit, and that the Division will not give continuing education credit to students who have taken courses that have not been properly certified. The process for an out-of-state provider to obtain certification of a course that is approved in other states will be revised to make sure that standards are met while not imposing an undue regulatory burden on the out-of-state provider.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 61-2-5.5(1)(a)(ii)

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: None--State government is not affected by the process of certification of continuing education providers for real estate agents. The Division of Real Estate will receive a modest additional amount of revenue in an amount that cannot be anticipated because of the rule change that eliminates a one-time certification, and therefore a one-time fee, for out-of-state providers. Those out-of-state providers will now have to pay the same certification and certification renewal fees every two years, the same as in-state providers.

❖ LOCAL GOVERNMENTS: None--Local governments are not in the business of providing continuing education to real estate agents.

❖ OTHER PERSONS: The only persons who could be affected by the changes to Section R162-9-2 would be real estate agents and the providers of their continuing education. If continuing education providers fail to have their courses certified for continuing education purposes before offering the courses to students, students who are not able to obtain continuing education credit for those courses will likely demand a tuition refund from the course providers. However, course providers can avoid this result by abiding by the rule and certifying their courses in advance. The changes to current Subsection R162-9-2(9.2.2) (now renumbered to 9.2.3) will eliminate a one-time approval, and therefore a one-time fee, that currently exists for some out-of-state providers. Although there is a streamlined certification process available to qualifying out-of-state providers, they will have to pay certification and renewal fees every two years like in-state providers instead of only paying a one-time fee.

COMPLIANCE COSTS FOR AFFECTED PERSONS: If continuing education providers fail to have their courses certified for continuing education purposes before offering the courses to students, students who are not able to obtain continuing education credit for those courses will likely demand a tuition refund from the course providers. However, course providers can avoid this result by complying with the rule and certifying their courses in advance. The changes to current Subsection R162-9-2(9.2.2) (now renumbered to 9.2.3) will eliminate a one-time approval, and therefore a one-time fee, that currently exists for some out-of-state providers. Although there is a streamlined certification process available to qualifying out-of-state providers, they will have to pay certification and renewal fees every two years like in-state providers instead of only paying a one-time fee.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule filing clarifies requirements for precertification of continuing education courses by course providers, establishes limited circumstances and standards for individual licensees to request credit for courses not certified by the Division, and establishes application procedures for providers of courses approved in other states. The only fiscal impact to businesses appears to be to out-of-state education providers who will now be required to pay required certification fees every two years like in-state providers. Russell C. Skousen, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

COMMERCE
 REAL ESTATE
 HEBER M WELLS BLDG
 160 E 300 S
 SALT LAKE CITY UT 84111-2316, or
 at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Shelley Wismer at the above address, by phone at 801-530-6761, by FAX at 801-530-6749, or by Internet E-mail at swismer@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: Dexter Bell, Director

**R162. Commerce, Real Estate.
 R162-9. Continuing Education.
 R162-9-2. Education Providers.**

9.2. Continuing education providers who provide education courses specifically tailored for, or marketed to, Utah real estate appraiser, or mortgage licensees, and who intend that real estate licensees shall receive continuing education credit for such courses, are required to apply to the Division for course certification [of their courses] prior to the courses being taught to students. Except as may be provided in Subsections 9.2.4, the Division will not grant continuing education credit to students who have taken courses that have not been certified by the Division in advance of the courses being taught to students.

9.2.1 Approved providers may include accredited colleges and universities, public or private vocational schools, national and state real estate related professional societies and organizations, real estate boards, and proprietary schools or instructors.

9.2.2 Application procedure. Except as provided in Subsection 9.2.3, education providers shall make application to the Division following the procedures set for in Section 9.5.

9.2.2]3 [Those] A real estate education provider[s] who provides proof to the division that the provider's course offering has[have] been certified for continuing education credit[courses] in a minimum of three other states and that the provider has[have]

specific standards in place for development of [their] courses and approval of [their] instructors[, and who will provide that criteria to the division of real estate for a one-time approval,] may be granted course certification [of their courses with no further application being necessary.] by filling out the form required by the Division and including with the application:

- (a) a copy of the provider's standards used for developing curricula and for approving instructors;
- (b) evidence that the course is certified in at least three states;
- (c) a sample of the course completion certification bearing all information required by Section 9.5.2.15; and
- (d) all required fees, which shall be nonrefundable.

9.2.3]9.2.4 Individual [E] licensees may apply to the [d] Division for continuing education credit for a non-certified real estate course that was not required by these rules to be certified in advance by the Division by filling out the form required by the Division and providing all information concerning the course required by the Division. [taken from a national provider that] If the licensee is able to demonstrate to the satisfaction of the Division that the course [believes] will likely improve [his] the licensee's ability to better protect or serve the public and improve the licensee's professional licensing status, the Division may grant the individual licensee continuing education credit for the course. [

9.2.3.1 A licensee may request approval of the course from the division and, for an appropriate fee, the division will review the merits of the non-certified course and determine whether the course meets the criteria for Utah real estate continuing education.]

9.2.4.1 Provided the subject matter of the course taken is not exclusive to the other state or jurisdiction, a course approved for continuing education in another state[.] or jurisdiction may be granted Utah continuing education credit on a case by case basis.

**KEY: continuing education
 [October 21, 2004]2005
 Notice of Continuation June 26, 2002
 61-2-5.5**

▼ ————— ▼
**Education, Administration
 R277-407
 School Fees**

**NOTICE OF PROPOSED RULE
 (Amendment)
 DAR FILE No.: 28064
 FILED: 07/01/2005, 15:16**

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule is amended to provide for changes to the law during the 2005 Legislative Session in H.B. 183. (DAR NOTE: H.B. 183 is found at UT L 2005 Ch 119, and was effective 05/02/2005.)

SUMMARY OF THE RULE OR CHANGE: The amendment provides for documentation of fee waivers consistent with Subsection 53A-12-103(5). The amendment also provides additional language regarding certification of compliance consistent with Doe v. Utah State Board of Education, Civil No. 920903376.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 53A-12-102(1), and Doe v. Utah State Board of Education, Civil No. 920903376

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: The need to make this rule consistent with state law necessitated revision of fee waiver information, application, and compliance forms. The cost to the State Office of Education for revision of the forms and translation of the forms into several languages was \$1,381. The translations are not complete, therefore, the cost is not a final expense.

❖ LOCAL GOVERNMENTS: The revised rule based on the changes in the law requires considerable additional local administrative work for verification of fee waivers and for arranging for work in lieu of fee waivers. Some school districts have suggested that an additional administrator (pay range of \$50,000 - \$80,000, depending on the school district), may be necessary to comply with the law. Other school districts' budgets allow for no additional administrators and the costs will have to be absorbed. Some school districts have proposed requiring school lunch staff to audit 100 percent of free school lunch applications. This may create conflicts with federal law and result in the necessity for school districts to hire additional staff.

❖ OTHER PERSONS: Parents may have minimal additional costs to copy and/or provide verification of income. There may also be additional costs for students working in lieu of fee waivers, possibly to include transportation for students and lost income to students who may miss after-school work time. Those costs for individual students and families are too speculative to estimate.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Parents may have minimal additional costs to copy and/or provide verification of income. There may also be additional costs for students working in lieu of fee waivers, possibly to include transportation for students and lost income to students who may miss after-school work time. Those costs for individual students and families are too speculative to estimate.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: I have reviewed this rule and I see no fiscal impact on businesses. Patti Harrington, State Superintendent of Public Instruction

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

EDUCATION
ADMINISTRATION
250 E 500 S
SALT LAKE CITY UT 84111-3272, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Carol Lear at the above address, by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: Carol Lear, Coordinator School Law and Legislation

R277. Education, Administration.

R277-407. School Fees.

R277-407-2. Authority and Purpose.

A. This rule is authorized under Article X, Sections 2 and 3 of the Utah Constitution which vests general control and supervision of the public education system in the State Board of Education and provides that public elementary and secondary schools shall be free except that fees may be imposed in secondary schools if authorized by the Legislature. Section 53A-12-102(1) authorizes the State Board of Education to adopt rules regarding student fees. This rule is consistent with the State Board of Education document, Principles Governing School Fees, adopted by the State Board of Education on March 18, 1994. This rule is also consistent with the Permanent Injunction, Doe v. Utah State Board of Education, Civil No. 920903376.

B. The purpose of this rule is:

(1) to permit the orderly establishment of a reasonable system of fees[?];

(2) to provide adequate notice to students and families of fee and fee waiver requirements; and

(3) ~~while~~to prohibit~~ing~~ practices that would exclude those unable to pay from participation in school-sponsored activities.

R277-407-3. Classes and Activities During the Regular School Day.

A. No fee may be charged in kindergarten through sixth grades for materials, textbooks, supplies, or for any class or regular school day activity, including assemblies and field trips.

B. Textbook fees may only be charged in grades seven through twelve.

C. If a class is established or approved which requires payment of fees or purchase of materials, tickets to events, etc., in order for students to participate fully and to have the opportunity to acquire all skills and knowledge required for full credit and highest grades, the class shall be subject to the fee waiver provisions of R277-407-6.

D. Students of all grade levels may be required to provide materials for their optional projects, but a student may not be required to select an optional project as a condition for enrolling in or completing a course. Project-related courses must be based upon projects and experiences that are free to all students.

E. Student supplies must be provided for elementary students. A student may, however, be required to replace supplies provided by the school which are lost, wasted, or damaged by the student through careless or irresponsible behavior.

F. Secondary students may be required to provide their own student supplies, subject to the provisions of Section R277-407-6.

R277-407-6. Waivers.

A. A local board of education shall provide, as part of any fee policy or schedule, for adequate waivers or other provisions in lieu of fee waivers to ensure that no student is denied the opportunity to participate in a class or school-sponsored or supported activity because of an inability to pay a fee.

The local board fee waiver policy shall include procedures to ensure that:

(1) at least one person at an appropriate administrative level is designated in each school to administer the policy and grant waivers;

(2) the process for obtaining waivers or pursuing alternatives is administered fairly, objectively, and without delay, and avoids stigma and unreasonable burdens on students and parents;

(3) students who have been granted waivers or provisions in lieu of fee waivers are not treated differently from other students or identified to persons who do not need to know;

(4) fee waivers or other provisions in lieu of fee waivers are available to any student whose parent is unable to pay the fee in question; fee waivers shall be verified by a school or school district administrator consistent with requirements of Section 53A-12-103(5);

(5) the local board requires documentation of fee waivers consistent with Section 53A-12-103(5);

(6) schools and the local board submit fee waiver compliance forms consistent with Doe v. Utah State Board of Education, Civil No. 920903376 that affirm compliance with provisions of the Permanent Injunction and provisions of Section 53A-12-103(5);

(7) the local board does not retain required fee waiver verification documentation for protection of privacy and confidentiality of family income records consistent with 53A-12-103(6);

~~(8)~~ textbook fees are waived for all eligible students in accordance with Sections 53A-12-201 and 53A-12-204 of the Utah Code and this Section;

~~(7)~~ parents are given the opportunity to review proposed alternatives to fee waivers;

~~(8)~~ a timely appeal process is available, including the opportunity to appeal to the local board or its designee;

~~(9)~~ any requirement that a given student pay a fee is suspended during any period during which the student's eligibility for waiver is being determined or during which a denial of waiver is being appealed; and

~~(10)~~ the local board provides for balancing of financial inequities among district schools so that the granting of waivers and provisions in lieu of fee waivers do not produce significant inequities through unequal impact on individual schools.

~~(B)~~ Eligibility

~~(a)~~ ~~(i)~~ Inability to pay is presumed for those who are in state custody or foster care, or receiving public assistance in the form of Aid to Families with Dependent Children, or Supplemental Security Income, or are eligible for free school lunch~~[-and]~~.

~~(b)~~ ~~2~~ CASE BY CASE DETERMINATIONS ~~[ARE]~~ SHALL BE MADE FOR THOSE WHO DO NOT QUALIFY UNDER ONE OF THE FOREGOING STANDARDS but who, because of extenuating circumstances such as, but not limited to, exceptional financial burdens such as loss or substantial reduction of income or extraordinary medical expenses, are not reasonably capable of paying the fee~~[-]~~.

C. No Child Nutrition Program funds may be used to administer the fee waiver program or fee waiver verification.

~~(B)~~ ~~(D)~~ Expenditures for uniforms, costumes, clothing, and accessories~~[-]~~ (other than items of typical student dress)~~[-]~~ which are required for school attendance, participation in choirs, pep clubs, drill teams, athletic teams, bands, orchestras, and other student groups, and expenditures for student travel as part of a school team, student group, or other school-approved trip, are fees requiring approval of the local board of education, and are subject to the provisions of this section, consistent with Doe v. Utah State Board of Education, Civil No. 920903376, p. 43.

~~(C)~~ ~~(E)~~ The requirements of fee waiver and availability of other provisions in lieu of fee waiver do not apply to charges assessed pursuant to a student's damaging or losing school property. Schools may pursue reasonable methods for obtaining payment for such charges, but may not exclude students from school or withhold UNOFFICIAL transcripts or diplomas to obtain payment of those charges, consistent with Section 53A-11-806(2), and the Family Educational Rights and Privacy Act of 1974 (FERPA), 20 USC 1232g, which regulation is hereby incorporated by reference within this rule.

~~(D)~~ ~~(F)~~ Charges for class rings, letter jackets, school photos, school yearbooks, and similar articles not required for participation in a class or activity are not fees and are not subject to the waiver requirements.

R277-407-7. Fee Waiver Reporting Requirements.

Beginning with fiscal year 1990-91, each school district shall attach to its annual S-3 statistical report for inclusion in the State Superintendent of Public Instruction's annual report the following:

(1) a summary of the number of students in the district given fee waivers, the number of students who worked in lieu of a waiver, and the total dollar value of student fees waived by the district;

(2) a copy of the local board's fee and fee waiver policies;

(3) a copy of the local board's fee schedule for students; and

(4) the notice of fee waiver criteria provided by the district to a student's parent or guardian.

(5) consistent fee waiver compliance forms provided by the USOE and required by Doe v. Utah State Board of Education, Civil No. 920903376.

KEY: education, educational tuition, education finance 2005

Notice of Continuation September 12, 2002

Art X Sec 3

53A-12-102

53A-12-201

53A-12-204

53A-11-806(2)

Doe v. Utah State Board of Education, Civil No. 920903376

Education, Administration

R277-451

The State School Building Program

NOTICE OF PROPOSED RULE

(Amendment)

DAR FILE No.: 28065

FILED: 07/01/2005, 15:33

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule is amended to provide for changes to the law during the 2005 Legislative Session in H.B. 124. (DAR NOTE: H.B. 124 is found at UT L 2005 Ch 171, and was effective 07/01/2005.)

SUMMARY OF THE RULE OR CHANGE: The amended rule includes adding and removing definitions, adding language on a district's yield per Average Daily Membership (ADM), and removing the requirement that a school district be a recipient of the Capital Outlay Foundation Program in order to qualify for Enrollment Growth Program funds.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 53A-21-103 and 53A-21-103.5

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: There are no anticipated cost or savings to the state budget. The rule amendments change the manner in which Enrollment Growth Program funds are distributed to school districts.

❖ LOCAL GOVERNMENTS: Preliminary estimates indicate that under the provisions outlined in the new legislation and this rule, 17 school districts would qualify for Enrollment Growth Program funds instead of 13 under current statutory provisions. The 2005 Legislature appropriated \$5,000,000 to fund this change.

❖ OTHER PERSONS: There are no anticipated cost or savings to other persons. Enrollment Growth Program funds are distributed to school districts.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs for affected persons. Enrollment Growth Program funds are distributed to school districts.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: I have reviewed this rule and I see no fiscal impact on businesses. Patti Harrington, State Superintendent of Public Instruction

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

EDUCATION
ADMINISTRATION
250 E 500 S
SALT LAKE CITY UT 84111-3272, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Carol Lear at the above address, by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at carol.lear@schools.utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: Carol Lear, Coordinator School Law and Legislation

R277. Education, Administration.**R277-451. The State School Building Program.****R277-451-1. Definitions.**

~~[A. "Accounts receivable" means any amount due the Board from a school district for which payment has not been received by the Board.~~

~~—B]A. "ADM" means Average Daily Membership of students.~~

~~[C. "Assessed valuation" means the assessed value of real property certified by the State Tax Commission to the Board each year.~~

~~—D]B. "Board" means the Utah State Board of Education.~~

~~[E]C. "Capital Outlay Foundation Program" means a program that provides a minimum dollar generation guarantee, per ADM, for every school district willing to levy a tax of .002400 per dollar of taxable value on real property, as provided in R277-451-3.~~

~~D. "Capital Outlay Loan Program" means a program that provides short-term assistance to school districts, for a period not to exceed five years, for school building construction and renovation, as provided in R277-451-6.~~

~~[F]E. "Derived assessed valuation" means current collections of tax levy (no prior year penalties or redemptions) divided by the same year tax rates.~~

~~[G]F. "Enrollment Growth Program" means a program that provides additional support to those school districts which are experiencing the most pressing needs for school facilities due to rapid growth, as provided in R277-451-4.~~

~~[H. "Fiscal year (FY)" means the twelve month period from July 1 through June 30 during which state funds are distributed.~~

~~—I]G. "Foundation level" means the guaranteed pro-rated amount per ADM to the extent of funds available distributed to school districts by the Board.~~

~~[J]H. "Loan" means a transaction which takes money from a Board account and places it in a school district account with the full legal intention by a school district that it be repaid to the account from which it was taken.~~

~~[K]I. "Superintendent" means the State Superintendent of Public Instruction.~~

~~[L]J. "USOE" means the Utah State Office of Education.~~

~~K. "Yield per ADM" means the product of the derived assessed valuation multiplied by .0024, divided by the average daily membership.~~

R277-451-2. Authority and Purpose.

A. This rule is authorized by Utah Constitution, Article X, Section 3 which vests general control and supervision of public education in the Board, Section 53A-21-103 which requires that the Board to adopt rules regarding qualifications for participation in the foundation program and distribution of funds for the program, Section 53A-21-103.5 which requires the Board to adopt rules regarding qualifications for participation in the Enrollment Growth Program and for distribution of funds for the program, and Section 53A-1-401(3) which permits the Board to adopt rules in accordance with its responsibilities.

B. The purpose of this rule is to specify the eligibility requirements and the procedures for distributing funds appropriated for the [e]Capital [o]Outlay [f]Foundation [p]Program and [e]Enrollment [g]Growth [p]Program as well as for providing short-term loans to school districts for capital outlay projects in school building construction and renovation.

R277-451-3. Capital Outlay Foundation Program.

A. A school district may receive state school building funds under the [e]Capital [o]Outlay [f]Foundation [p]Program established in Section 53A-21-102(1) if the amount raised by levying a tax rate of .002400 does not generate revenues above the foundation level established per ADM when the legislative appropriation is entered into the formula.

B. To qualify to receive 100 percent of the [e]Capital [o]Outlay [f]Foundation funds available to a school district, a school district shall levy a property tax rate of at least 0.002400 designated specifically for capital outlay and debt service:

(1) school districts levying less than the full 0.002400 tax rate for capital outlay and debt service shall receive proportional funding under the capital foundation program based upon the percentage of the 0.002400 tax rate levied by the school district;

(2) the amount of capital foundation funds to which a school district would otherwise be entitled under the Capital Outlay Foundation [p]Program may not be reduced as a consequence of changes in the certified tax rate under Section 59-2-924 due to changes in property valuation for a period of two tax years from the effective date of any such change in the certified tax rate.

C. The USOE shall support the foundation program to assist the qualifying school district in reaching the foundation level.

R277-451-4. Enrollment Growth Program.

A. A school district may receive [e]Enrollment [g]Growth [p]Program funds under Section 53A-21-103.5 for the following purposes:

- (1) to fund general obligation bond principal and interest costs;
- (2) to fund construction;
- (3) to fund facilities renovation; and
- (4) to fund other capital project needs as approved.

B. In order to qualify for monies under the Enrollment Growth Program, a school district ~~[shall be a recipient of monies distributed under the Capital Outlay Foundation Program and]~~shall have had an average net increase in student enrollment over the previous three years from the year in which money is requested under the Enrollment Growth Program and yield per ADM is less than two times the prior year's average yield per ADM for Utah school districts.

~~[C. If a school district was or is not a recipient of Capital Outlay Foundation Program monies in FY 2003-04 or FY 2004-05, the school district may qualify for monies under the Enrollment Growth Program if the school district received Capital Outlay Foundation Program monies in FY 2002-03.~~

~~—D]C.~~ School districts receive Enrollment Growth Program monies in the same proportion that the school district's three-year average net increased enrollment bears to the total three-year net increased enrollment of all the school districts which qualify to receive funds under the Enrollment Growth Program.

R277-451-5. When Funds are Distributed.

Capital Outlay Foundation and Enrollment Growth Program funds shall be distributed through the monthly electronic bank transfer to school districts as early as possible after the data elements are received from school districts and entered into the formulae, typically before the February bank transfer.

R277-451-6. Capital Outlay Loan Program.

A. A school district may receive [e]Capital [o]Outlay [h]Loan [p]Program funds under Section 53A-21-102 which establishes a [e]Capital [o]Outlay [h]Loan [p]Program to provide short-term assistance to school districts, for a period not to exceed five years, for school building construction and renovation.

B. To be a priority qualifier for the [e]Capital [o]Outlay [h]Loan [p]Program, a school district shall satisfy all of the following criteria:

(1) demonstrate an ability and commitment as demonstrated by a local board vote to set the levy at the rate needed to repay the loan within the time period prescribed by the loan agreement; and

(2) levy a tax rate for capital outlay and debt service above the state average; and

(3) demonstrate a school district need that is better met through the loan fund than through more traditional means for providing school building construction or renovation or both.

C. If a school district does not meet the criteria for a priority qualifier and the needs of the priority qualifiers are met, the loan application of school districts not meeting this criteria may be considered, if the school district commits to levying at or above the state average for the next tax year. In the case of a natural disaster or other compelling emergency, this requirement may be waived by the Superintendent.

D. A school district applying for a short term loan under this rule shall make a formal application which includes:

(1) the emergency condition or the condition that exists that would be better met through the loan fund rather than through more traditional means for providing school building construction or renovation or both;

(2) the amount of loan sought;

(3) the proposed repayment schedule, not to exceed five years;

(4) the history of the last five years of loans or special supplementary funds received by the school district from the USOE;

(5) minutes of the local board meeting recording the affirmative vote to levy the needed tax; and

(6) a signed agreement that if the school district should default on a loan payment, the Superintendent may deduct the loan payment and added interest from the calculated per school district state distribution after 90 days.

E. The loan request and repayment conditions shall be approved by the Superintendent after receiving recommendations from a loan approval committee, including representatives from state and local education entities.

F. If the loan approval committee recommends approval of the loan application, the committee's recommendations shall include:

(1) the recommendation amount of the loan;

(2) the repayment schedule; and

(3) the interest rate to be charged. It is the intent of the Board that the interest rate be based upon the Delphis Hanover Corp. triple A interest rate less 1/2 percent, as quoted 30 days before the loan date and dependent upon the term of the loan.

KEY: educational facilities, education finance
~~November 2, 2004~~ **2005**
 Notice of Continuation September 7, 2004
 Art X Sec 3
 53A-21-103
 53A-21-103.5
 53A-1-401(3)
 59-2-924

▼ ————— ▼

Environmental Quality, Water Quality **R317-1** Definitions and General Requirements

NOTICE OF PROPOSED RULE
 (Amendment)
 DAR FILE No.: 28054
 FILED: 06/29/2005, 17:32

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The proposed changes update portions of the rule that address effluent reuse. These changes are proposed to bring the rule up to current industry standards, provide clarifying language and to make technical adjustments needed after about a decade of experience with the rule. Many changes are in response to input received from the regulated community, and/or from benchmarking surveys conducted by staff. The proposed changes have been reviewed and recommended by the Reuse Subcommittee of the Water Environment Association of Utah.

SUMMARY OF THE RULE OR CHANGE: The proposed changes relate to the portions of the rule addressing effluent reuse. Sections R317-1-3 and R317-1-4 have been amended. Proposed changes include adjusting technical requirements appropriate with current industry standards, removing old deadlines, and several "case by case" references. Some application, testing, and management requirements for water reuse projects were also modified.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 19, Chapter 5

ANTICIPATED COST OR SAVINGS TO:

- ❖ **THE STATE BUDGET:** No costs or savings are anticipated as the proposed changes are technical in nature and will not require additional state resources.
- ❖ **LOCAL GOVERNMENTS:** A slight, one time increase in engineering costs may occur from slightly increased administrative requirements in the application process for a water reuse project. These costs are likely to be offset by savings realized from reduced effluent quality testing requirements.
- ❖ **OTHER PERSONS:** The proposed amendments address effluent reuse by wastewater treatment plants. No impacts to other persons are anticipated.

COMPLIANCE COSTS FOR AFFECTED PERSONS: A slight, one time increase in engineering costs may occur from slightly increased administrative requirements in the application process for a water reuse project. These costs are likely to be offset by savings realized from reduced effluent quality testing requirements.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: No additional impact on businesses is expected. Cost impacts are limited to governmental entities. Dianne R. Nielson, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

ENVIRONMENTAL QUALITY
 WATER QUALITY
 CANNON HEALTH BLDG
 288 N 1460 W
 SALT LAKE CITY UT 84116-3231, or
 at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

John Kennington at the above address, by phone at 801-538-6713, by FAX at 801-538-6016, or by Internet E-mail at jkennington@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 09/01/2005

AUTHORIZED BY: Dianne R. Nielson, Executive Director

R317. Environmental Quality, Water Quality. R317-1. Definitions and General Requirements. R317-1-3. Requirements for Waste Discharges.

3.1 ~~[Deadline For]~~ Compliance With Water Quality Standards.

All persons discharging wastes into any of the waters of the State ~~[on the effective date of these regulations]~~ shall provide the degree of wastewater treatment determined necessary to insure compliance with the requirements of R317-2 (Water Quality Standards) ~~[as soon as practicable but not later than June 30, 1983]~~, except that the Board may ~~[, on a case by case basis, allow an extension to the deadline for]~~ waive compliance with these requirements for specific criteria listed in R317-2 where it is determined that the designated use is not being impaired or significant use improvement would not occur or where there is a reasonable question as to the validity of a specific criterion or for other valid reasons as determined by the Board.

3.2 ~~[Deadline For]~~ Compliance With Secondary Treatment Requirements.

All persons discharging wastes from point sources into any of the waters of the State shall provide treatment processes which will produce secondary effluent meeting or exceeding the following effluent quality standards.

A. The arithmetic mean of BOD values determined on effluent samples collected during any 30-day period shall not exceed 25 mg/l, nor shall the arithmetic mean exceed 35 mg/l during any 7-day period. In addition, if the treatment plant influent is of domestic or municipal

sewage origin, the BOD values of effluent samples shall not be greater than 15% of the BOD values of influent samples collected in the same time period. As an alternative, if agreed to by the person discharging wastes, the following effluent quality standard may be established as a requirement of the discharge permit and must be met: The arithmetic mean of CBOD values determined on effluent samples collected during any 30-day period shall not exceed 20 mg/l nor shall the arithmetic mean exceed 30 mg/l during any 7-day period. In addition, if the treatment plant influent is of domestic or municipal sewage origin, the CBOD values of effluent samples shall not be greater than 15% of the CBOD values of influent samples collected in the same time period.

B. The arithmetic mean of SS values determined on effluent samples collected during any 30-day period shall not exceed 25 mg/l, nor shall the arithmetic mean exceed 35 mg/l during any 7-day period. In addition, if the treatment plant influent is of domestic or municipal sewage origin, the SS values of effluent samples shall not be greater than 15% of the SS values of influent samples collected in the same time period.

C. The geometric mean of total coliform and fecal coliform bacteria in effluent samples collected during any 30-day period shall not exceed either 2000 per 100 ml or 200 per 100 ml respectively, nor shall the geometric mean exceed 2500 per 100 ml or 250 per 100 ml respectively, during any 7-day period; or, the geometric mean of E. coli bacteria in effluent samples collected during any 30-day period shall not exceed 126 per 100 ml nor shall the geometric mean exceed 158 per 100 ml respectively during any 7-day period. Exceptions to this requirement may be allowed by the Board ~~[on a case-by-case basis]~~ where domestic wastewater is not a part of the effluent and where water quality standards are not violated.

D. The effluent values for pH shall be maintained within the limits of 6.5 and 9.0.

E. Exceptions to the 85% removal requirements may be allowed ~~[on a case-by-case basis]~~ where infiltration makes such removal requirements infeasible and where water quality standards are not violated.

F. The Board may allow exceptions to the requirements of (A), (B) and (D) above ~~[on a case-by-case basis]~~ where the discharge will be of short duration and where there will be of no significant detrimental affect on receiving water quality or downstream beneficial uses.

G. The Board may allow ~~[on a case-by-case basis]~~ that the BOD5 and TSS effluent concentrations for discharging domestic wastewater lagoons shall not exceed 45 mg/l for a monthly average nor 65 mg/l for a weekly average provided the following criteria are met:

1. The lagoon system is operating within the organic and hydraulic design capacity established by R317-3,
2. The lagoon system is being properly operated and maintained,
3. The treatment system is meeting all other permit limits,
4. There are no significant or categorical industrial users (IU) defined by 40 CFR Part 403, unless it is demonstrated to the satisfaction of the Executive Secretary to the Utah Water Quality Board that the IU is not contributing constituents in concentrations or quantities likely to significantly effect the treatment works,
5. A Waste Load Allocation (WLA) indicates that the increased permit limits would not impair beneficial uses of the receiving stream.

3.3 Extensions To Deadlines For Compliance.

The Board may, upon application of a waste discharger, allow extensions ~~[on a case-by-case basis]~~ to the compliance deadlines in Section 1.3.2 above where it can be shown that despite good faith effort, construction cannot be completed within the time required.

3.4 Pollutants In Diverted Water Returned To Stream.

A user of surface water diverted from waters of the State will not be required to remove any pollutants which such user has not added before returning the diverted flow to the original watercourse, provided there is no increase in concentration of pollutants in the diverted water. Should the pollutant constituent concentration of the intake surface waters to a facility exceed the effluent limitations for such facility under a federal National Pollutant Discharge Elimination System permit or a permit issued pursuant to State authority, then the effluent limitations shall become equal to the constituent concentrations in the intake surface waters of such facility. This section does not apply to irrigation return flow.

R317-1-4. Utilization and Isolation of Domestic Wastewater Treatment Works Effluent.

4.1 Untreated Domestic Wastewater. Untreated domestic wastewater or effluent not meeting secondary treatment standards as defined by these regulations shall be isolated from all public contact until suitably treated. Land disposal or land treatment of such wastewater or effluent may be accomplished by use of an approved total containment lagoon as defined in R317-3 or by such other treatment approved by the Board as being feasible and equally protective of human health and the environment.

4.2 Submittal of Reuse Project Plan. If a person intends to reuse or provide for the reuse of treated domestic wastewater directly for any purpose, except on the treatment plant site as described in R317-1-4.6, a Reuse Project Plan must be submitted to and approved by the Division of Water Quality. A copy of the plan must also be submitted to the local health department. Any needed construction of wastewater treatment and delivery systems would also be covered by a construction permit as required in section R317-1-2.2 of this rule. The plan must contain the following information. At least items ~~A~~ B, C, E and F should be provided before construction begins. All items must be provided before any water deliveries are made.

A. A description of the source, quantity, quality, and use of the treated wastewater to be delivered, the location of the reuse site, an assessment of the direct hydrologic effects of the action, and how the requirements of this rule would be met. A nutrient management and agronomic uptake analysis may be required to document the proposed management of all nutrients.

B. A description of public notification and participation in the development of the Reuse Project Plan may be required.

~~B~~C. Evidence that the State Engineer has agreed that the proposed reuse project planned water use is consistent with the water rights for the sources of water comprising the flows to the treatment plant which will be used in the reuse project.

~~C~~D. An operation and management plan to include:

1. A copy of the contract with the user, if other than the treatment entity.

2. A labeling and separation plan for the prevention of cross connections between ~~reclaimed~~reuse water distribution lines and potable water lines. Guidance for distribution systems is available from the Division of Water Quality.

3. Schedules for routine maintenance.

4. A contingency plan for system failure or upsets.

~~D~~E. If the water will be delivered to another entity for distribution and use, a copy of the contract covering how the requirements of this rule will be met.

F. Requirements for ground water discharge permits, underground injection control (U.I.C.) permits, surface water discharge permits, total maximum daily load (TMDL) or nutrient loading considerations, if required, shall be determined in accordance with R317-1, R317-2, R317-6, R317-7, R317-8.

4.3 Use of Treated Domestic Wastewater Effluent Where Human Exposure is Likely (Type I)

A. Uses Allowed

1. Residential irrigation, including landscape irrigation at individual houses.

2. Urban uses, which includes non-residential landscape irrigation, golf course irrigation, toilet flushing, fire protection, and other uses with similar potential for human exposure. Internal building uses of reuse water will not be allowed in individual, wholly-owned residences; and are only permitted in situations where maintenance access to the building's utilities is strictly controlled and limited only to the services of a professional plumbing entity. Projects involving effluent reuse within a building must be approved by the local building code official.

3. Irrigation of food crops where the applied ~~[reclaimed]~~reuse water is likely to have direct contact with the edible part. Type I water is required for all spray irrigation of food crops.

4. Irrigation of pasture for milking animals.

5. Impoundments of wastewater where direct human contact is likely to occur.

6. All Type II uses listed in 4.4.A below.

B. Required Treatment Processes

1.a. ~~[Secondary t]Treatment processes[, which may include activated sludge, trickling filters, rotating biological contactors, oxidation ditches, and stabilization ponds. The secondary treatment process] that[should] are expected to produce effluent in which both the BOD and total suspended solids concentrations do not exceed [25 mg/l as a monthly mean]secondary quality effluent limits as defined in R317-1-3.2.~~

2.b. Filtration, which includes passing the wastewater through filter media such as sand and/or anthracite or approved membrane processes.

3.c. Disinfection to destroy, inactivate, or remove pathogenic microorganisms by chemical, physical, or biological means. Disinfection may be accomplished by chlorination, ozonation, or other chemical disinfectants, UV radiation, ~~[membrane processes,]~~ or other approved processes.

2. Other approved treatment processes in which any of the unit process functions of secondary treatment, filtration and disinfection may be combined, but still achieve the same secondary quality effluent limits as required above.

C. Water Quality Limits. The quality of effluent before use must meet the following standards. Testing methods and procedures shall be performed according to ~~[Standards Methods for Examination of Water and Wastewater, eighteenth edition, 1992]test procedures approved under R317-2-10,~~ or as otherwise approved by the Executive Secretary.

1. The monthly arithmetic mean of BOD shall not exceed 10 mg/l as determined by ~~[daily]~~ composite sampling conducted once per week. Composite samples shall be comprised of at least six flow proportionate samples taken over a 24-hour period.

2. The daily arithmetic mean turbidity shall not exceed 2 NTU, and turbidity shall not exceed 5 NTU at any time. Turbidity shall be measured continuously. The turbidity standard shall be met prior to disinfection. If the turbidity standard cannot be met, but it can be demonstrated to the satisfaction of the Executive Secretary that there exists a consistent correlation between turbidity and the total suspended

solids, then an alternate turbidity standard may be established. This will allow continuous turbidity monitoring for quality control while maintaining the intent of the turbidity standard, which is to have 5 mg/l total suspended solids or less to assure adequate disinfection.

3. The weekly median E. coli concentration shall be none detected, as determined from daily grab samples, and no sample shall exceed 9 organisms/100 ml.

4. The total residual chlorine shall be measured continuously and shall at no time be less than 1.0 mg/l after 30 minutes contact time at peak flow. If an alternative disinfection process is used, it must be demonstrated to the satisfaction of the Executive Secretary that the alternative process is comparable to that achieved by chlorination with a 1 mg/l residual after 30 minutes contact time. If the effectiveness cannot be related to chlorination, then the effectiveness of the alternative disinfection process must be demonstrated by testing for pathogen destruction as determined by the Executive Secretary. A 1 mg/l total chlorine residual is ~~[required]~~recommended after disinfection and before the ~~[reclaimed]~~reuse water goes into the distribution system.

5. The pH as determined by daily grab samples or continuous monitoring shall be between 6 and 9.

D. Other Requirements

1. An alternative disposal option or diversion to storage must be automatically activated if turbidity exceeds the maximum instantaneous limit for more than 5 minutes, or chlorine residual drops below the instantaneous required value for more than 5 minutes, where chlorine disinfection is used.

2. Any irrigation must be at least 50 feet from any potable water well. Impoundments of ~~[reclaimed]~~reuse water, if not sealed, must be at least 500 feet from any potable water well. The use should not result in a surface runoff and must not result in the creation of an unhealthy or nuisance condition, as determined by the local health department.

~~[3. Requirements for ground water discharge permits, if required, shall be determined in accordance with R317-6.~~

~~—4]3.~~ For residential landscape irrigation at individual homes, additional quality control restrictions may be required by the Executive Secretary. Proposals for such uses should also be submitted to the local health authority to determine any conditions they may require. When secondary residential irrigation systems are planned utilizing reuse water in new subdivisions, it is recommended that a notification of the type of irrigation system and possible sources of irrigation waters be made on the deed for the property. Such notification could be made during the plat approval process.

4.4 Use of Treated Domestic Wastewater Effluent Where Human Exposure is Unlikely (Type II)

A. Uses Allowed

1. Irrigation of sod farms, silviculture, limited access highway rights of way, and other areas where human access is restricted or unlikely to occur.

2. Irrigation of food crops where the applied ~~[reclaimed]~~reuse water is not likely to have direct contact with the edible part, whether the food will be processed or not (spray irrigation not allowed).

3. Irrigation of animal feed crops other than pasture used for milking animals.

4. Impoundments of wastewater where direct human contact is not allowed or is unlikely to occur.

5. Cooling water. Use for cooling towers which produce aerosols in populated areas may have special restrictions imposed.

6. Soil compaction or dust control in construction areas.

B. Required Treatment Processes

1. ~~[Secondary t]Treatment processes[, which may include activated sludge, trickling filters, rotating biological contactors,~~

~~oxidation ditches, and stabilization ponds. Secondary treatment should be provided for all wastewater treatment plants that are expected to produce effluent in which both the BOD and total suspended solids concentrations do not exceed 25 mg/l as a monthly mean secondary quality effluent limits as defined in R317-1-3.2.~~

2. Disinfection to destroy, inactivate, or remove pathogenic microorganisms by chemical, physical, or biological means. Disinfection may be accomplished by chlorination, ozonation, or other chemical disinfectants, UV radiation, ~~membrane processes,~~ or other approved processes.

C. Water Quality Limits. The quality of effluent before use must meet the following standards. Testing methods and procedures shall be performed according to ~~[Standards Methods for Examination of Water and Wastewater, eighteenth edition, 1992] test procedures approved under R317-2-10,~~ or as otherwise approved by the Executive Secretary.

1. The monthly arithmetic mean of BOD shall not exceed 25 mg/l as determined by ~~weekly~~ composite sampling ~~conducted once per week.~~ Composite samples shall be comprised of at least six flow proportionate samples taken over a 24-hour period.

2. The monthly arithmetic mean total suspended solids concentration shall not exceed 25 mg/l as determined by daily composite sampling. The weekly mean total suspended solids concentration shall not exceed 35 mg/l. Properly calibrated, continuous monitoring of turbidity may be substituted for the suspended solids testing.

3. The weekly median E. coli concentration shall not exceed 126 organisms/100 ml, as determined from daily grab samples, and no sample shall exceed 500 organisms/100 ml.

4. The pH as determined by daily grab samples or continuous monitoring shall be between 6 and 9.

5. At the discretion of the Executive Secretary, the sampling frequency to determine compliance with water quality limits for effluent from lagoon systems used to irrigate agricultural crops, may be reduced to monthly grab sampling for BOD, and weekly grab sampling for E. coli, TSS and pH. The Water Quality Board may also allow a relaxation of lagoon effluent BOD and suspended solids concentrations, in accordance with R317-1-3.2.

D. Other Requirements

1. An alternative disposal option or diversion to storage must be available in case quality requirements are not met.

2. Any irrigation must be at least 300 feet from any potable water well. Spray irrigation must be at least ~~300~~100 feet from areas intended for public access. This distance may be reduced or increased by the Executive Secretary, based on the type of spray irrigation equipment used and other factors. Impoundments of ~~reclaimed~~ reuse water, if not sealed, must be at least 500 feet from any potable water well. The use should not result in a surface runoff and must not result in the creation of an unhealthy or nuisance condition, as determined by the local health department.

~~[3. Requirements for ground water discharge permits, if required, shall be determined in accordance with R317-6.~~

~~4]3.~~ Public access to effluent storage and irrigation or disposal sites shall be restricted by a stock-tight fence or other comparable means which shall be posted and controlled to exclude the public.

4.5 Records. Records of volume and quality of treated wastewater delivered for reuse shall be maintained and submitted monthly in accordance with R317-1-2.7. If monthly operating reports are already being submitted to the Division of Water Quality, the data on water delivered for reuse may be submitted on the same form.

4.6 Use of Secondary Effluent at Plant Site. Secondary effluent may be used at the treatment plant site in the following manner provided there is no cross-connection with a potable water system:

A. Chlorinator injector water for wastewater chlorination facilities, provided all pipes and outlets carrying the effluent are suitably labeled.

B. Water for hosing down wastewater clarifiers, filters and related units, provided all pipes and outlets carrying the effluent are suitably labeled.

C. Irrigation of landscaped areas around the treatment plant from which the public is excluded.

4.7 Other Uses of Effluents. Proposed uses of effluents not identified above, including industrial uses, shall be considered for approval by the Board based on a case-specific analysis of human health and environmental concerns.

4.8 ~~Reclaimed~~ Reuse Water Distribution Systems. Where ~~reclaimed~~ reuse water is to be provided by pressure pipeline, unless contained in surface pipes wholly on private property and for agricultural purposes, the following requirements will apply. The requirements will apply to all new systems ~~constructed after May 4, 1998,~~ and it is recommended that the accessible portions of existing ~~reclaimed~~ reuse water distribution systems be retrofitted to comply with these rules. Requirements for secondary irrigation systems proposed for conversion from use of non-~~reclaimed~~ reuse water to use with ~~reclaimed~~ reuse water will be considered on an individual basis considering protection of public health and the environment. Any person or agency that is constructing all or part of the distribution system must obtain a construction permit from the Division of Water Quality prior to beginning construction.

A. Distribution Lines

1. Minimum Separation.

a. Horizontal Separation. ~~Reclaimed~~ reuse water main distribution lines parallel to potable (culinary) water lines ~~shall~~ should be installed in separate trenches, at least ten feet horizontally from the potable water lines. ~~Reclaimed~~ Reuse water main distribution lines parallel to sanitary sewer lines shall be installed at least ten feet horizontally from the sanitary sewer line if the sanitary sewer line is located above the ~~reclaimed~~ reuse water main and three feet horizontally from the sanitary sewer line if the sanitary sewer line is located below the ~~reclaimed~~ reuse water main.

b. Vertical Separation. At crossings of ~~reclaimed~~ reuse water main distribution lines with potable water lines and sanitary sewer lines the order of the lines from lowest in elevation to highest should be; sanitary sewer line, ~~reclaimed~~ reuse water line, and potable water line. A minimum 18 inches vertical separation between ~~these utilities~~ the reuse water line and sewer line shall be provided as measured from outside of pipe to outside of pipe. The crossings shall be arranged so that the ~~reclaimed~~ reuse water line joints will be equidistant and as far as possible from the water line joints and the sewer line joints. If the ~~reclaimed~~ reuse water line must cross above the potable water line, the vertical separation ~~shall~~ should be a minimum 18 inches ~~and the reclaimed water line shall be encased in a continuous pipe sleeve to a distance on each side of the crossing equal to the depth of the potable water line from the ground surface.~~ If the ~~reclaimed~~ reuse water line must cross below the sanitary sewer line, the vertical separation shall be a minimum 18 inches and the ~~reclaimed~~ reuse water line shall be encased in a continuous pipe sleeve to a distance on each side of the crossing equal to the depth of the ~~reclaimed~~ reuse water line from the ground surface.

c. Special Provisions. Where the horizontal and/or vertical separation as required above cannot be maintained, special construction requirements shall be provided in accordance with requirements in R317-3 for protection of potable water lines and reuse water lines.

Existing pressure lines carrying [reclaimed]reuse water shall not be required to meet these requirements.

2. Depth of Installation. To provide protection of the installed pipeline, [reclaimed]reuse water lines should be installed with a minimum depth of bury of three feet.

3. [Reclaimed]Reuse Water Pipe Identification.

a. General. All new buried pipe within the public domain, including service lines, valves, and other appurtenances, shall be colored purple, Pantone 522 or equivalent. If fading or discoloration of the purple pipe is experienced during construction, identification tape is recommended. Locating wire along the pipe is also recommended.

b. Identification Tape. If identification tape is installed along with the purple pipe, it shall be prepared with white or black printing on a purple field, color Pantone 512 or equivalent, having the words, "Caution: [Reclaimed]Reuse Water-- Do Not Drink". The overall width of the tape shall be at least three inches. Identification tape shall be installed 12 inches above the transmission pipe longitudinally and shall be centered.

4. Conversion of existing water lines. Existing water lines that are being converted to use with [reclaimed]reuse water shall first be accurately located and comply with leak test standards in accordance with AWWA Standard C-600 and in coordination with regulatory agencies. The pipeline must be physically disconnected from any potable water lines and brought into compliance with current State cross connection rules and requirements (R309-102-5), and must meet minimum separation requirements in section 4.8.A.1 of this rule above. If the existing lines meet approval of the water supplier and the Division, the lines shall be approved for [reclaimed]reuse water distribution. If regulatory compliance of the system (accurate location and verification of no cross connections) cannot be verified with record drawings, televising, or otherwise, the lines shall be uncovered, inspected, and identified prior to use. All accessible portions of the system must be retrofitted to meet the requirements of this rule.

5. Valve Boxes and Other Surface Identification. All valve covers shall be of non-interchangeable shape with potable water covers, and shall have an inscription cast on the top surface stating "Reclaimed Water" or "Reuse Water". Valve boxes shall meet AWWA standards. All above ground facilities shall be consistently color coded (purple, Pantone 512 or equivalent color) and marked to differentiate [reclaimed]reuse water facilities from potable water facilities.

6. Blow-off Assemblies. If either an in-line type or end-of-line type blow-off or drain assembly is installed in the system, the Division of Water Quality shall be consulted on acceptable discharge or runoff locations.

B. Storage. If storage or impoundment of [reclaimed]reuse water is provided, the following requirements apply:

1. Fencing. For Type I effluent, no fencing is required by this rule, but may be required by local laws or ordinances. For Type II effluent, see R317-1-4.4.D.[4] above.

2. Identification. All storage facilities shall be identified by signs prepared according to the requirements of Section 4.8.D.6 below. Signs shall be posted on the surrounding fence at minimum 500 foot intervals and at the entrance of each facility. If there is no fence, signs shall be located as a minimum on each side of the facility or at minimum 250 foot intervals or at all accessible points.

C. Pumping Facilities.

1. Marking. All exposed and above ground piping, fittings, pumps, valves, etc., shall be painted purple, Pantone 512 or equivalent color. In addition, all piping shall be identified using an accepted means of labeling reading "Caution: [Reclaimed]Reuse Water - Do Not Drink." In a fenced pump station area, signs shall be posted on the fence on all sides.

2. Sealing Water. Any potable water used as seal water for [reclaimed]reuse water pumps seals shall be protected from backflow with a reduced pressure principle device.

D. Other Requirements.

1. Backflow Protection. In no case shall a connection be made between the potable and [reclaimed]reuse water system. If it is necessary to put potable water into the [reclaimed]reuse distribution system, an approved air gap must be provided to protect the potable water system. A reduced pressure principle device may be used only when approved by the Division of Water Quality, the local health department, and the potable water supplier.

2. Drinking Fountains. Drinking fountains and other public facilities shall be placed out of any spray irrigation area in which [reclaimed]reuse water is used, or shall be otherwise protected from contact with the [reclaimed]reuse water. Exterior drinking fountains and other public facilities shall be shown and called out on the construction plans. If no exterior drinking fountains, picnic tables, food establishments, or other public facilities are present in the design area, then it shall be specifically stated on the plans that none are to exist.

3. Hose Bibs. Hose bibs on [reclaimed]reuse water systems in public areas and at individual residences ~~shall be prohibited.~~ are permitted, with the following restrictions:

a. All exposed hose bib piping must be painted purple, Pantone 512 or equivalent color and,

b. Hose bibs shall be fitted with a valve having a non-permanently attachable operating handle. To discourage inappropriate casual use, it is recommended that each hose bib be posted with a warning label or sign, as detailed in R317-1-4.8, and/or placed in a lockable subsurface valve box in accordance with R317-1-4.8.

In public, non-residential areas, replacement of hose bibs with quick couplers is recommended.

4. Equipment and Facilities. To ensure the protection of public health, any equipment or facilities such as tanks, temporary piping or valves, and portable pumps which have been used for conveying [reclaimed]reuse water may not be reused for conveying potable water.

5. Warning Labels. Warning labels shall be installed on designated facilities such as, but not limited to, controller panels and washdown or blow-off hydrants on water trucks, and temporary construction services. The labels shall indicate the system contains [reclaimed]reuse water that is unsafe to drink.

6. Warning signs. Where [reclaimed]reuse water is stored or impounded, or used for irrigation in public areas, warning signs shall be installed and contain, as a minimum, 1/2 inch purple letters (Pantone 512 or equivalent color) on a white or other high contrast background notifying the public that the water is unsafe to drink. Signs may also have a purple background with white or other high contrast lettering. Warning signs and labels shall read, "Warning: [Reclaimed]Reuse Water - Do Not Drink". The signs shall include the international symbol for Do Not Drink.

7. Public Education Program. Where reuse water is used in individual residential landscape or public landscape area irrigation systems, a public education program must be implemented prior to initial operation of the program and, as necessary, during operation of the system.

KEY: water pollution, waste disposal, industrial waste, effluent standards

2005

Notice of Continuation October 7, 2002

19-5



**Health, Health Care Financing,
Coverage and Reimbursement Policy
R414-504
Nursing Facility Payments**

NOTICE OF PROPOSED RULE

(Amendment)

DAR FILE NO.: 28066

FILED: 07/01/2005, 16:21

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rulemaking is necessary to simplify and improve the accuracy of nursing facility rate calculations.

SUMMARY OF THE RULE OR CHANGE: This rulemaking amends the nursing facility payments rule by specifying the months of the year in which the nursing facility rates will be adjusted, and specifying the 3-month period of case mix data to be included in the calculation of the case mix component of the rate.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 26-1-5 and 26-18-3

ANTICIPATED COST OR SAVINGS TO:

❖ **THE STATE BUDGET:** There is no impact to the state budget because the clarifications in this rulemaking do not change the amount of state and federal funds that will be distributed to regulated health care facilities.

❖ **LOCAL GOVERNMENTS:** There is no budget impact to local governments because the clarifications in this rulemaking do not change the amount of state and federal funds that will be distributed to regulated health care facilities.

❖ **OTHER PERSONS:** There is no budget impact to other persons because the clarifications in this rulemaking do not change the amount of state and federal funds that will be distributed to regulated health care facilities.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs because the clarifications in this rulemaking do not change the amount of state and federal funds that will be distributed to regulated health care facilities.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule clarification makes current policy of the Department on rate setting clearer and will not have a negative fiscal impact on this industry. David N. Sundwall, MD, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH

HEALTH CARE FINANCING,

COVERAGE AND REIMBURSEMENT POLICY

CANNON HEALTH BLDG

288 N 1460 W

SALT LAKE CITY UT 84116-3231, or

at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Craig Devashrayee at the above address, by phone at 801-538-6641, by FAX at 801-538-6099, or by Internet E-mail at cdevashrayee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: David N. Sundwall, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.

R414-504. Nursing Facility Payments.

R414-504-3. Principles of Facility Case Mix Rates and Other Payments.

The following principles apply to the payment of freestanding and provider based nursing facilities for services rendered to nursing care level I, II, and III Medicaid patients, as defined in R414-502. This rule does not affect the system for reimbursement for intensive skilled Medicaid patients.

(1) Approximately 59% of total payments in aggregate to nursing facilities for nursing care level I, II and III Medicaid patients are based on a prospective facility case mix rate. In addition, these facilities shall be paid a flat basic operating expense payment equal to approximately 29% of the total payments. The balance of the total payments will be paid in aggregate to facilities as required by R414-504-3 based on other authorized factors, including property and behaviorally complex residents, in the proportion that the facility qualifies for the factor.

(2) Pending federal approval of the Medicaid rate adjustment, the request to allow the implementation of the Utah Nursing Care Facility Assessment Act, and consequent rules, the case mix rate in effect on July 2, 2004, as well as other components of the total rate will be the same as those in effect on June 30, 2004.

(3) Upon federal approval of the nursing care facility rate adjustment and the assessment pursuant to R414-504-3(2), rate components will be adjusted retroactively to July 2, 2004, to reflect

the additional funding made available. The adjusted rate will be further adjusted retroactive to September 15, 2004 to include the application of a Fair Rental Value reimbursement system for property as addressed in R414-504-3(7).

(4) The Department calculates ~~each nursing facility's~~ a new case mix index for each nursing facility quarterly. ~~The case mix index is based [up] on [the previous] 3[-] months [moving average case mix history] of MDS assessment data.~~ The newly calculated case mix index is applied to ~~the case mix~~ a new rate ~~[one month after] at the [end of the] beginning of a quarter according to the following schedule[-]:~~

(a) January, February and March MDS assessments are used for July 1 rates.

(b) April, May and June MDS assessments are used for October 1 rates.

(c) July, August and September MDS assessments are used for January 1 rates.

(d) October, November and December MDS assessments are used for April 1 rates.

(e) To ensure the inclusion of all MDS assessments, the initial MDS dataset used to calculate case mix under this section includes all months not previously used in a case mix calculation.

(5) A facility may apply for a special add-on rate for behaviorally complex residents by filing a written request with the Division of Health Care Financing. The Department may approve an add-on rate if an assessment of the acuity and needs of the patient demonstrates that the facility is not adequately reimbursed by the RUGS score for that patient. The rate is added on for the specific resident's payment and is not subsumed as part of the facility case mix rate. The Resident Assessment Section will make the determination as to qualification for any additional payment. The Division of Health Care Financing shall determine the amount of any add-on.

(6) Property costs are paid separately from the RUGS rate.

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KEY: Medicaid
2005
26-1-5
26-18-3
26-35a



**Health, Health Systems Improvement,
 Emergency Medical Services
 R426-15-200
 Staffing**

NOTICE OF PROPOSED RULE
 (Amendment)
 DAR FILE NO.: 28038
 FILED: 06/20/2005, 12:03

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The proposed amendment codifies the practice of having one paramedic transport a patient in certain situations. It will not diminish the responsibility for paramedic providers to have two paramedics on-scene at all emergencies, but will enable them to transport the patient to the emergency patient receiving facility using either one or two paramedics according to instructions received from on-line medical control.

SUMMARY OF THE RULE OR CHANGE: This change eliminates the requirement for a paramedic ambulance to always have two paramedics transport a patient to a patient receiving facility regardless of the condition of the patient. It enables on-line medical control to determine whether either one or two paramedics can provide the transport. If there is only one paramedic required for transport, there will also be an Emergency Medical Technician (EMT)-Basic, EMT-Intermediate, or EMT-Intermediate Advanced to accompany the single paramedic during the transport.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 26-8a-105

ANTICIPATED COST OR SAVINGS TO:

❖ **THE STATE BUDGET:** There will be no cost or savings to the state budget since this will not diminish the need for certification and recertification of paramedics since there is still the requirement for two paramedics to be at the scene of all ambulance calls.

❖ **LOCAL GOVERNMENTS:** There will be no cost or savings to local government paramedic ambulance providers because the staffing at the scene of all ambulance calls will not be reduced. It may reduce the need to call back paramedics for subsequent calls but that can only be determined after a time period of evaluation once the rule is effective.

❖ **OTHER PERSONS:** There will be no cost or savings to private paramedic ambulance providers because the staffing at the scene of all ambulance calls will not be reduced. It may reduce the need to call back paramedics for subsequent calls but that can only be determined after a time period of evaluation once the rule is effective. Since there is no change in the rate structure attached to this rule, there will be no savings or cost to any patients or third-party payers.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There will be no compliance costs since all affected persons will still be required to have the same number of paramedics respond. This proposed rule carries no new licensure level or any increased obligations for affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule change is supported by most emergency medical services. The rule change places the decision-making responsibility with the responders on scene and on-line medical control rather than having transport staffing mandated by rule without regard to patient needs. The fiscal impact will be neutral or positive on businesses. David N. Sundwall, MD, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH
HEALTH SYSTEMS IMPROVEMENT,
EMERGENCY MEDICAL SERVICES
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY UT 84116-3231, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Paul Patrick at the above address, by phone at 801-538-6291, by FAX at 801-538-6808, or by Internet E-mail at paulpatrick@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: David N. Sundwall, Executive Director

R426. Health, Health Systems Improvement, Emergency Medical Services.

R426-15. Licensed and Designated Provider Operations.

R426-15-200. Staffing.

(1) EMT ground ambulances, while providing ambulance services, shall have the following minimum complement of personnel:

(a) two attendants, each of whom is a certified EMT-Basic, EMT-Intermediate, EMT-Intermediate Advanced, or Paramedic.

(b) a driver, 18 years of age or older, who is the holder of a valid driver's license. If the driver is also an EMT-Basic, EMT-Intermediate, EMT-Intermediate Advanced, or Paramedic, the driver qualifies as one of the two required attendants.

(c) EMT ground ambulance services authorized by the Department to provide Intermediate or Intermediate Advanced services shall assure that at least one EMT-Intermediate or EMT-Intermediate Advanced responds on each call along with another certified EMT.

(d) if on-line medical control determines the condition of the patient to be "serious or potentially critical," at least one paramedic shall accompany the patient on board the ambulance to the hospital, if a Paramedic rescue is on scene.

(e) if on-line medical control determines the condition of the patient to be "critical," the ambulance driver and two Paramedics shall accompany the patient on board the ambulance to the hospital, if Paramedics are on scene.

(2) Quick response units, while providing services, shall have the following minimum complement of personnel:

(a) one attendant, who is an EMT-Basic, EMT-Intermediate, EMT-Intermediate Advanced, or Paramedic.

(b) quick response units authorized by the Department to provide Intermediate services shall assure that at least one EMT-Intermediate, EMT Intermediate Advanced or Paramedic responds on each call.

(3) Paramedic ground ambulance or rescue services shall have the following minimum complement of personnel:

(a) staffing at the scene of an accident or medical emergency shall be no less than two persons, each of whom is a Paramedic;

(b) a paramedic ground ambulance service, while providing paramedic ambulance services, shall have: ~~two attendants, each of whom is a Paramedic;~~

~~(c) a driver, 18 years of age or older, who is the holder of a valid driver's license. If the driver is also a Paramedic, the driver qualifies as one of the two required attendants; [and~~

~~(d) if a paramedic ground ambulance has been requested by a transferring physician for inter facility movement of a patient, the staffing shall be as follows:~~

~~(i) if on-line medical control determines the physician describes the condition of the patient as "serious or potentially critical," a minimum staffing shall be of one Paramedic, and one EMT-Basic, EMT-Intermediate, or EMT Intermediate Advanced; and~~

~~(ii) if on-line medical control determines the physician describes the condition of the patient as "critical," a minimum staffing shall be of an ambulance driver and two Paramedics.~~

(4) Paramedic inter-facility transfer services shall have the following minimum complement of personnel:

(a) if the physician describes the condition of the patient as "serious or potentially critical," minimum staffing shall be one Paramedic, and one EMT-Basic, EMT-Intermediate, or EMT-Intermediate Advanced;

(b) if the physician describes the condition of the patient as "critical," minimum staffing shall be two Paramedics and an ambulance driver.

(5) Each licensee shall maintain a personnel file for each certified individual. The personnel file must include records documenting the individual's qualifications, training, certification, immunizations, and continuing medical education.

(6) An EMT or Paramedic may only perform to the service level of the licensed or designated service, regardless of the certification level of the EMT or Paramedic.

KEY: emergency medical services

~~[February 1,]2005~~

Notice of Continuation October 1, 2004

26-8a



**Human Services, Services for People
with Disabilities**

R539-7

Home Based Services

NOTICE OF PROPOSED RULE

(Repeal)

DAR FILE NO.: 28036

FILED: 06/20/2005, 10:21

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The change is proposed after a comprehensive revision and consolidation of the Division's rules.

SUMMARY OF THE RULE OR CHANGE: The changes involve repealing the current rule and placing these service descriptions in the Provider's service contracts with the Division. This rule is repealed in its entirety.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 62A-5-102 and 62A-5-103

ANTICIPATED COST OR SAVINGS TO:

❖ **THE STATE BUDGET:** None--This revision does not alter the basic operations or functions of the Division and therefore, does not result in either cost or savings to the state.

❖ **LOCAL GOVERNMENTS:** None--Local government funding is not used, therefore, there is no cost to local governments.

❖ **OTHER PERSONS:** None--This revision does not alter the basic operations or functions of the Division and therefore, does not result in either a cost or savings to other persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--This revision does not alter the basic operations and functions of the Division. Provider requirements now appear in their current service contracts. This does not result in either a cost or savings to providers or other affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: None--This revision does not alter the basic operations of functions of the Division. Provider requirements now appear in their current service contracts. This does not changes the fiscal impact on service providers. Lisa-Michele Church, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HUMAN SERVICES
SERVICES FOR PEOPLE WITH DISABILITIES
Room 411
120 N 200 W
SALT LAKE CITY UT 84103-1500, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Steven Bradford at the above address, by phone at 801-538-4197, by FAX at 801-538-4279, or by Internet E-mail at sbradford@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 09/15/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 09/16/2005

AUTHORIZED BY: George Kelner, Director

R539. Human Services, Services for People with Disabilities.

~~**R539-7. Home Based Services.**~~

~~**R539-7-1. Family Training and Assistance.**~~

~~**A. Policy.**~~

~~Family Training and Assistance provides direct supports/services to families of people with disabilities so that the family can live as~~

~~much like other families as possible, and enhance their ability to meet the many needs of their family member with a disability. The supports/services that a family receives shall be determined by the individual and family, based on their culture, values, preferences, and specific needs any given time.~~

~~**B. Procedures.**~~

~~1. Family Training and Assistance can involve any number or types of supports/services. These supports/services may address not only the needs of the person with a disability, but other family members as well. The main goals of Family Training and Assistance supports/services are:~~

~~a. To keep families together until the person with a disability chooses to live independently.~~

~~b. To allow the family to participate fully in the community.~~

~~c. To make a positive difference in the life of a person with a disability as well as the lives of all family members.~~

~~d. To minimize the need and cost of out of home placement.~~

~~2. Procedures may vary among Division regional offices, but will remain consistent with:~~

~~a. The region staff will determine the individual's eligibility according to R539-1-1, Eligibility for Services, and a region case manager will complete an assessment of supports/services needed by the individual and the family.~~

~~b. If the family has chosen:~~

~~(1) a provider agency, the case manager will ensure that the agency has a contract and is certified according to R539-6-7, Licensing and Certification, and R539-6-4, Training Requirements for Family Support and Respite Care Providers.~~

~~(2) a parent choice provider, the case manager will ensure that the form 945, Purchase of Individual Family Support Agreement, is signed and that any requested screening has been completed and that a provider file has been completed on each parent choice provider according to R539-6-7, Licensing and Certification.~~

~~**R539-7-2. Respite Services.**~~

~~**A. Policy.**~~

~~The Division of Services for People with Disabilities will contract to provide respite services for individuals with disabilities who are living in their family home, in Professional Parent homes, or are eligible individuals living in a foster care setting. The purpose of respite is to provide intermittent, time limited care to eligible individuals to enable parents and primary caretakers relief from the demands of parenting and living with a person with disabilities.~~

~~**B. Procedures.**~~

~~1. Respite care services should offer the least possible departure from the normal patterns of living, while still being effective in meeting the person's needs. Agency respite providers shall comply with R539-6-4, Training Requirements for Family Support and Respite Care Providers, and R539-6-7, Licensing and Certification. Respite services may be provided at an hourly or daily rate, and respite may be provided in home or out of home.~~

~~a. The hourly rate is used when respite is provided up to no more than six hours/day.~~

~~b. The daily rate is used when respite is provided over six hours/day.~~

~~c. In Home Respite Care services are provided in the home of the individual with a disability. Family members may or may not be at home during this time. Respite care providers are specially trained and skilled persons who come into a family's home to care for a family member with disabilities. The services provided shall depend entirely on the needs of the families and family members involved.~~

—d. Out-of-Home Respite Care services are provided in the private home of the respite provider. In rare situations and upon approval of the Emergency Services Management Committee and the region office, care may be provided in a nursing facility or specialized facility designed to provide respite care.

—2. The Provider will coordinate the delivery of respite services to be provided with the region case manager, family member or primary caretaker, and person with a disability.

—3. The Provider will document and report to the region case manager the individual's response to the respite placement and will coordinate with any applicable Individual Family Support Plan outcomes.

—4. The Provider will maintain documentation of injuries and accidents.

—5. No more than two individuals with disabilities will be served by any respite provider at any one time, unless the region director has reviewed the Individual's Family Support Plan and has approved the provider to serve additional persons; however, the number of individuals with disabilities served by a respite provider at any one time shall never exceed four individuals.

R539-7.3. Educational Services.

—A. Policy.

—Educational services provide opportunities for Division eligible adults to obtain education instruction, individual tutoring, and the opportunity to participate in generic educational classes or seminars that will enhance their life and support them to learn and maintain the life skills necessary to succeed in an inclusive society.

—B. Procedures.

—1. The provider will have applicable credentials or license for providing the educational service desired.

—2. The individual will have a statement of need for the educational service in his/her plan of care.

—3. If the individual receives this service funded through the Home and Community-Based Waiver, then the individual shall have the following documentation in their individual file:

—a. That this service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142; and

—b. That the individual has been deinstitutionalized from a nursing facility or intermediate care facility, at some prior time.

—4. The provider will comply with Division and Department requirements for working with persons with disabilities.

R539-7.4. Personal Assistance Services.

—A. Policy.

—The Personal Assistance Services program provides adults with physical disabilities the maximum control to live as independently as possible in their choice of home, community and daily activities by providing funding to purchase assistant services. Personal Assistance Services are provided in the recipient's own home or apartment, or community.

—B. Procedures.

—1. Personal Assistance Services include all activities of daily living necessary to maintain well-being, personal appearance, comfort, safety and interactions within the community.

—2. Each participant recruits and hires the person(s) to perform the needed attendant services.

—3. The participant trains and supervises all activities performed by their employee(s) and has full responsibility for reimbursement, including payment of taxes.

—4. The use of Personal Assistance Services Funds for any purpose other than to purchase or arrange for attendant services may result in suspension or discontinuation of Personal Assistance Services benefits.

—5. Each participant will be reviewed annually by the Division specialist to determine satisfaction with existing services and to evaluate the continuing level of needed services.

—6. Monthly benefit amounts shall be determined according to the number of hours of personal assistance provided through the Division not to exceed 84 hours per week unless approved by the Division Director.

R539-7.5. Child Care Services.

—A. Policy.

—The Division of Services for People with Disabilities may provide supplemental funding for child care for children with disabilities 12 years old and younger who are eligible for Division services and who are living with family; or funding for Latch key services supervision to children with disabilities 13 years of age and older who are eligible for Division services, who are living with family, and whose parents are working or going to school. Latch Key services may be provided only when no other education or child care programs are available.

—B. Procedures.

—1. Child care providers shall meet the child care licensing or certification requirements in accordance with R539-6-7, Licensing and Certification.

—2. Parents are responsible to ensure that the basic fee for child care is paid to the provider of services. Child care providers receiving supplemental child care must write a plan of care, indicating the additional services the child will receive, which will be added to the child's Individual Family Support Plan in accordance with the Division's Policy #302.1, Individual Family Support Plan.

—3. Latch Key services shall be provided under contract between the region and child care providers at the approved Division rate. Latch Key providers must write a plan of care, indicating the services the child will receive, which will be added to the child's Individual Family Support Plan in accordance with Division Policy #302.1, Individual Family Support Plan.

KEY: disabled persons*, social services

March 18, 1996

Notice of Continuation December 18, 2002

62A-5-103]



Insurance, Administration **R590-126** Individual and Franchise Disability Insurance, Minimum Standards

NOTICE OF PROPOSED RULE

(Repeal and Reenact)

DAR FILE No.: 28044

FILED: 06/28/2005, 07:42

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule is being revised for a number of reasons: 1) it has been 10 years since substantive changes have been made to the rule;

2) the insurance industry has requested the update; 3) minimum benefit levels are being raised to correspond with rising health care costs; 4) the rule is being made to more closely correspond with the National Association of Insurance Commissioner's (NAIC) Model Regulation on minimum standards; and 5) the rule scope is being broadened to clarify that this rule encompasses more than just individual insurance plans.

SUMMARY OF THE RULE OR CHANGE: The original rule included major medical which is not included in the rewrite. The major changes being made in the new rule are: 1) minimum benefit levels are being raised to correspond to rising health care costs; 2) new definitions are being added, i.e., "scientific evidence," "medical necessity," "accident," and "accidental injury" based on industry input and other Insurance Department rules; 3) the probationary period for specific diseases and conditions has been revised to conform with the NAIC's Model Regulation; and 4) the new rule includes standards for dental and vision plans.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 31A-2-201, 31A-2-202, 31A-23-312, 31A-22-605, 31A-22-623, 31A-22-626, 31A-23-302, and 31A-26-301

ANTICIPATED COST OR SAVINGS TO:

- ❖ **THE STATE BUDGET:** The proposed changes to this rule will increase the department's workload due to the need to review policy forms that insurers will be required to refile with the department. Approximately 600 health insurers may be affected by the changes in the rule and will need to change and file policy forms, however, no filing fee is required.
- ❖ **LOCAL GOVERNMENTS:** The changes to this rule will not affect local government since the rule only applies to the relationship between health insurers, consumers, and the department.
- ❖ **OTHER PERSONS:** Approximately 600 health insurers may be affected by the changes to this rule and will need to change and file policy forms, however, no filing fee is required. Some benefit requirements in the rule have been increased, but most health insurers have already been providing increased benefits to their insureds. As a result, there should be no significant increase in costs to the insurance companies or their insureds.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Approximately 600 health insurers may be affected by the changes to this rule and will need to change and file policy forms, however, no filing fee is required. Some benefit requirements in the rule have been increased, but most health insurers have already been providing increased benefits to their insureds. As a result, there should be no significant increase in costs to the insurance companies or their insureds.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Benefit levels are being raised to correspond with rising health care costs. Most health insurers have already been providing these increased benefits to their insureds and as a result there should be no significant increased costs to health insurers. D. Kent Michie, Commissioner

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

INSURANCE
ADMINISTRATION
Room 3110 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY UT 84114-1201, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Jilene Whitby at the above address, by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at jwhitby@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005

INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE: 8/08/2005 at 9:00 AM, State Office Building (behind the Capitol), Room 3112, Salt Lake City, UT.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: Jilene Whitby, Information Specialist

R590. Insurance, Administration.

~~**R590-126. Individual and Franchise Disability Insurance, Minimum Standards.**~~

~~**R590-126-1. Authority.**~~

~~— This rule is issued by the Insurance Commissioner pursuant to Subsection 31A-2-201(3)(a) authorizing rules to implement the Insurance Code and Section 31A-22-605 requiring the commissioner to adopt rules to establish minimum standards for disclosure in the sale of, and benefits to be provided by, Individual and Franchise Disability Insurance.~~

~~**R590-126-2. Purpose and Scope.**~~

~~— A. Purpose. The purpose of this rule is to provide reasonable standardization and simplification of terms and coverages of insurance policies in order to facilitate public understanding and comparison and to prohibit provisions which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of such insurance.~~

~~— B. Scope. This rule shall apply to all individual and franchise disability insurance policies, including health maintenance organization contracts, and subscriber contracts of hospital, medical and dental service corporations. Individual conversion policies shall be subject to this rule except where Section 31A-22-701, et. seq., U.C.A., requires otherwise. A policy or certificate characterized as "group insurance," but marketed to individuals, shall be subject to this rule. The rule shall apply only to coverage issued after the effective date of the rule.~~

~~**R590-126-3. Definitions.**~~

~~— A. In addition to the definitions of Sections 31A-1-301 and 31A-22-605(2), U.C.A., the following definitions shall apply for the purposes of this rule:~~

—1. "Accident" or "Accidental Injury."

a. The definition of these terms may not be more restrictive than the following: "Injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause and occurs while insurance coverage is in force."

b. The definition shall employ "result" language and may not include the phrase "Accidental Means," or words which establish an accidental means test, or use words such as "external, violent, visible wounds" or similar words of description or characterization.

c. Unless otherwise prohibited by law, the definition may exclude injuries for which benefits are paid under worker's compensation, an employer's liability or similar law, or a motor vehicle no fault plan.

—2. "Adult Day Care" shall mean a licensed group program designed to meet the needs of functionally impaired adults for a period of fewer than 24 hours per day. Such care may be provided by persons without nursing skills or qualification.

—3. "Certificate of Completion" shall mean a document issued by the Utah Board of Education to a person who completes an approved course of study not leading to a diploma, or to one who passes a challenge for that same course of study, or to one whose out of state credentials and certificate are acceptable to the Board.

—4. "Cold lead advertising" shall mean making use, directly or indirectly, of any method of marketing which fails to disclose, in a conspicuous manner, that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

—5. "Complications of pregnancy" shall mean diseases or conditions the diagnoses of which are distinct from pregnancy but are adversely affected or caused by pregnancy and not associated with a normal pregnancy.

a. "Complications of Pregnancy" include acute nephritis, nephrosis, cardiac decompensation, ectopic pregnancy which is terminated, a spontaneous termination of pregnancy when a viable birth is not possible, puerperal infection, eclampsia and toxemia.

b. This definition does not include false labor, occasional spotting, doctor prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy.

—6. "Cosmetic Surgery" or "Reconstructive Surgery" shall mean any surgical procedure performed primarily to improve physical appearance.

a. This definition does not include surgery which is necessary:

i. To correct damage caused by injury or sickness;

ii. For reconstructive treatment following medically necessary surgery;

iii. To provide or restore normal bodily function; or

iv. To correct a congenital disorder that has resulted in a functional defect.

b. This provision does not require coverage for preexisting conditions otherwise excluded.

—7. "Custodial Care" shall mean a Plan of Care which does not provide treatment for sickness or injury, but is only for the purpose of meeting personal needs and maintaining physical condition when there is no prospect of effecting remission or restoration of the patient to a condition in which care would not be required. Such care may be provided by persons without nursing skills or qualifications. If a Nursing Care Facility is only providing custodial or residential care, the level of care may be so characterized.

—8. "Elimination Period" or "Waiting Period" shall mean the specified number of consecutive days at the start of each period of disability for which no benefits are payable.

—9. "Experimental Treatment" is defined as medical treatment, services, supplies, medications, drugs, or other methods of therapy or medical practices which are not accepted as a valid course of treatment by your state's medical association, the U.S. Food and Drug Administration, the American Medical Association, or the Surgeon-General.

—10. "Health Care Expenses" shall mean expenses of health maintenance organizations associated with the delivery of health care services which are analogous to incurred losses of insurers. Such expenses may not include:

a. Home office and overhead costs;

b. Advertising costs;

c. Commissions and other acquisition costs;

d. Taxes;

e. Capital costs;

f. Administrative costs;

g. Claims processing costs.

—11. "High pressure tactics" shall mean employing any method of marketing which induces or attempts to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or excessive pressure.

—12. "Home Health Agency" shall mean a public agency or private organization, or subdivision of a health care facility, duly licensed and operating within the scope of such license.

—13. "Home Health Aide" shall mean a person who obtains a Certificate of Completion, as required by law, which allows performance of health care and other related services under the supervision of a Registered Nurse from the Home Health Agency, or performance of simple procedures as an extension of physical, speech, or occupational therapy under the supervision of licensed therapists.

—14. "Home Health Care" shall mean services provided by a Home Health Agency.

—15. "Homemaker" shall mean a person who cares for the environment in the home through performance of duties such as housekeeping, meal planning and preparation, laundry, shopping and errands.

—16. "Homemaker/Home Health Aide" shall mean a person who has obtained a Certificate of Completion, as required by law, which allows performance of both Homemaker and Home Health Aide services, and who provides health care and other related services under the supervision of a Registered Nurse from the Home Health Agency or under the supervision of licensed therapists.

—17. "Hospice" shall mean a program of care for the terminally ill and their families which occurs in a home or in a health care facility and which provides medical, palliative, psychological, spiritual, or supportive care and treatment.

—18. "Hospital" shall mean a facility duly licensed and operating within the scope of such license. This definition may not preclude the requirement of medical necessity of hospital confinement or other treatment.

—19. "Intermediate Nursing Care" shall mean nursing services provided by, or under the supervision of, a Registered Nurse (R.N.). Such a Plan of Care shall be for the purpose of treating the condition for which confinement is required.

—20. "Medically Necessary" shall mean treatment or services which are necessary and appropriate for the diagnosis or treatment

of an illness or injury based on generally accepted current medical practice.

— 21. "Medicare" shall be defined in any hospital, surgical or medical expense policy which relates its coverage to eligibility for Medicare or Medicare benefits. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Laws 89-97, and Amendments Thereto, Popularly Known as the Health Insurance for the Aged Act, as Enacted by the Eighty Ninth Congress of the United States of America," or words of similar import.

— 22. "Medicare Supplement Policy" shall mean an individual, franchise, or group policy of disability insurance which is advertised, marketed, or primarily designed as a supplement to reimbursements under Medicare for hospital, medical, or surgical expenses of persons eligible for Medicare.

— 23. "Mental or Nervous Disorders" may not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or any other mental or emotional disease or disorder which does not have a demonstrable organic cause.

— 24. "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as Registered Nurse (R.N.), or Licensed Practical Nurse (L.P.N.). If the words "Nurse" or "Registered Nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with applicable statutes or administrative rules.

— 25. "Nurse, Licensed Practical" shall mean a person who is registered and licensed to practice as a Practical Nurse.

— 26. "Nurse, Registered" shall mean any person who is registered and licensed to practice as a Registered Nurse.

— 27. "Nursing Care" shall mean assistance provided for the health care needs of sick or disabled individuals, by or under the direction of licensed nursing personnel.

— 28. "Nursing Care Facility," or "Nursing Home," shall mean a facility duly licensed and operating within the scope of such license.

— 29. "One Period of Confinement" shall mean consecutive days of in-hospital service received as an inpatient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time of not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy up to a maximum of 180 days.

— 30. "Partial Disability" shall be defined in relation to the individual's inability to perform one or more but not all of the "major," "important," or "essential" duties of employment or occupation or may be related to a "percentage" of time worked or to a "specified number of hours" or to "compensation." Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

— 31. "Personal Care" shall mean assistance, under a Plan of Care by a Home Health Agency, provided to persons in activities of daily living.

— 32. "Personal Care Aide" shall mean a person who obtains a Certificate of Completion, as required by law, which allows that person to assist in the activities of daily living and emergency first aid, and who must be supervised by a Registered Nurse from the Home Health Agency.

— 33. "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician." The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical

care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws as required by Section 31A-22-618, U.C.A.

— 34. "Plan of Care" shall mean a written plan based on assessment data or physician orders that identifies the patient's needs, who will provide needed services and how often, treatment goals, and anticipated outcomes.

— 35. "Preexisting Condition" may not be defined to be more restrictive than the following:

— a. Specified Disease Insurance. "Preexisting condition" shall mean a condition which first manifested itself within six months prior to the effective date of coverage or which was diagnosed by a physician at any time prior to the effective date of coverage.

— b. Other Health Coverage. "Preexisting condition" shall mean the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a five-year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a five-year period preceding the effective date of the coverage of the insured person.

— 36. "Probationary Period" shall mean the period of time following the date of issuance or effective date of the policy before coverage begins for all or certain conditions.

— 37. "Residential Health Care Facility" shall mean a publicly or privately operated and maintained facility providing personal care to residents who require protected living arrangements.

— 38. "Residual Disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important," or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required.

A policy which provides for residual disability benefits may require a qualification period, during which the insured shall be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import which in the opinion of the commissioner adequately and fairly describes the benefit.

— 39. "Respite Care" shall mean provision of temporary support to the primary caregiver of the aged, disabled, or handicapped individual insured, by taking over the tasks of that person for a limited period of time. The insured may receive care in the home, or other appropriate community location, or in an appropriate institutional setting.

— 40. "Sickness."

— a. The definition of this term may not be more restrictive than the following: "Sickness means sickness or disease of an insured person which manifests itself after the effective date of insurance and while the insurance is in force."

— b. A definition of sickness may provide for a probationary period which may not exceed 30 days from the effective date of the coverage of the insured person.

— c. The definition may be further modified to exclude sickness or disease for which benefits are paid under any worker's compensation, occupational disease, employer's liability or similar law.

— 41. "Skilled Nursing Care" shall mean nursing services provided by, or under the supervision of, a Registered Nurse (R.N.). Such a Plan of Care shall be for the purpose of treating the

condition for which the confinement is required and not for the purpose of providing Intermediate or Custodial Care.

—42. "Therapist" may be defined as a professionally trained or duly licensed or registered person, such as a physical therapist, occupational therapist, or speech therapist, who is skilled in applying treatment techniques and procedures under the general direction of a physician.

—43. "Total Disability:"

a. A general definition of total disability may not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he is or becomes qualified by reason of education, training or experience; and not, in fact, engaged in any employment or occupation for wage or profit.

b. Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to:

i. Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation," or

ii. Engage in any training or rehabilitation program.

c. An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his regular occupation or words of similar import.

d. An insurer may require care by a physician other than the insured or a member of the insured's immediate family.

—44. "Twisting" shall mean knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or attempting to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out another policy of insurance.

—45. "Usual and Customary" shall mean the reasonable, usual and customary charges for services and supplies in the community where such services and supplies were provided.

—46. "Waiting Period" shall mean "Elimination Period."

R590-126-4. General Requirements.

A. Policy Definitions. No policy subject to this rule may contain definitions respecting the matters defined in Section R590-126-3 unless such definitions comply with the requirements of that section.

B. Rights of Spouse. The following provisions apply to policies which provide coverage to a spouse of the insured:

1. Termination of Spouse Limited. A policy may not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than for nonpayment of premium.

2. Spouse as Insured. A policy shall provide that in the event of the insured's death the spouse of the insured shall become the insured.

3. Age Determination. The age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the noncancellation or renewal provisions of the policy. However, this requirement may not prevent termination of coverage of the older spouse upon attainment of the stated age limit, e.g., age 65, so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in said definition.

C. Renewability.

1. Disclosure. The terms "noncancellable," "guaranteed renewable," "noncancellable and guaranteed renewable,"

"conditionally renewable," "collectively renewable," or "optionally renewable" may not be used without further explanatory language in accordance with the disclosure requirements of Subsection R590-126-6(B).

2. Disability Income—Effect of Employment Upon Right to Renew. Any accident and health or accident only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy at least to age 60 if, at age 60, the insured has the right to continue the policy in force at least to age 65 while actively and regularly employed.

3. Cancellation and Renewal.

a. Noncancellable. The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy at least to age 65 or to eligibility for Medicare, during which period the insurer has no right to make any unilateral change to the detriment of the insured while the policy is in force.

b. Guaranteed Renewable. Except as provided above, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums at least to age 65 or to eligibility for Medicare, during which period the insurer has no right to make any unilateral change to the detriment of the insured while the policy is in force, except that the insurer may make changes in premium rates by classes.

c. Conditionally Renewable. The term "conditionally renewable" may be used only in a policy which the insured may have the right to continue in force by the timely payment of premiums at least to age 65 or to eligibility for Medicare, during which period the insurer has no right to make any unilateral change to the detriment of the insured while the policy is in force. However, the insurer, at its option, and by timely notice, may decline renewal for reasons stated in the policy, or may make changes in premium rates by classes.

d. Collectively Renewable. The term "collectively renewable" may be used only in a policy which the insured may have the right to continue in force by the timely payment of premiums at least to age 65 or to eligibility for Medicare, during which period the insurer has no right to make any unilateral change in any provision of the policy while the policy is in force. However, the insurer, at its option, and by timely notice, may decline renewal of all policies of the same classification issued in this state, or may make changes in premium rates by classes.

e. Optionally Renewable. The term "optionally renewable" may be used only in a policy which the insured may have the right to continue in force by the timely payment of premiums at least to age 65 or to eligibility for Medicare, during which period the insurer has no right to make any unilateral change in any provision of the policy while the policy is in force. However, the insurer, at its option, and by timely notice, may decline renewal of the policy or may make changes in premium rates by classes.

f. Notice of nonrenewal or premium change. A notice of nonrenewal or change in premium shall be given no fewer than 30 days before the renewal date.

D. Optional insureds. When accidental death and dismemberment coverage is part of the insurance coverage offered under the contract, the insured shall have the option to include all insureds under such coverage and not just the principal insured.

—E. Refund of Premium. If a policy contains a status type military service exclusion or a provision which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rata basis.

—F. Pregnancy Benefit Extension. In the event the insurer cancels or refuses to renew, except for nonpayment of premiums, policies providing pregnancy benefits shall provide for an extension of benefits for a pregnancy, including complications of pregnancy, commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

—G. Post hospital Admission Requirements. Policies providing convalescent or extended care benefits following hospitalization may not condition such benefits upon admission to the convalescent or extended care facility within a period of fewer than 14 days after discharge from the hospital.

—H. Handicapped Dependent Coverage Extension. Family coverage shall continue for any dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap and is chiefly dependent on the insured for support and maintenance on the date that such child's coverage would otherwise terminate under the policy due to the attainment of a specified age limit for children. The policy may require that within 31 days of such date the company receive due proof of such incapability in order for the insured to elect to continue the policy in force with respect to such child, or that a separate converted policy be issued at the option of the insured or policyholder.

—I. Transplant Donor Coverage. Any policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

—J. Recurrent Disability. A policy may contain a provision relating to recurrent disabilities, but no such provision may specify that a recurrent disability be separated by a period greater than six months.

—K. Time Limit for Occurrence of Loss. Accidental death and dismemberment benefits shall be payable if the loss occurs within 180 days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, may not require the loss to commence fewer than 30 days after the date of accident, nor may any policy which the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

—L. Dismemberment Benefits. Specific dismemberment benefits may not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

—M. Accident Benefits. Any accident-only policy providing benefits which vary according to the type of accidental cause shall prominently set forth, in both the policy and the outline of coverage, the circumstances under which benefits are payable which are less than the maximum amount payable under the policy.

—N. Continuous Total Disability. Termination of a policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

—O. Deterioration of Health. A policy may not be cancelled or nonrenewed by an insurer solely on the grounds of deterioration of health.

R590-126-5. Prohibited Policy Provisions.

—A. Probationary periods. No policy may contain provisions establishing either a probationary or a waiting period during which coverage is not provided under the policy, except as follows in Subsections (1) and (2):

—1. A probationary period of 30 days may apply under the definition of "sickness" contained in Subsection R590-126-3(A)(4) of this rule.

—2. A probationary period of up to six months may be applied to the following specified diseases or conditions and losses resulting therefrom:

- a. Hernia;
- b. Disorder of reproductive organs;
- c. Varicose veins;
- d. Adenoids;
- e. Appendix;
- f. Tonsils.

—3. The six month exception of Subsection R590-126-5(A)(2) may not be applicable where such specified diseases or conditions are treated on an emergency basis.

—4. Accident policies may not contain either probationary or waiting periods:

—B. "Dividend" coverage.

—1. Cash Payment. No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider may be issued for an initial term of fewer than six months.

—2. Optional Renewal. The initial renewal subsequent to the issuance of any policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that such renewal is optional with the policyholder.

—C. Preexisting Conditions. No policy may exclude coverage for a loss due to a preexisting condition for a period greater than 12 months (six months for specified disease policies) following policy issue where the application for such insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and such preexisting condition is not specifically excluded by the terms of the policy.

—D. "Return of Premium" or "Cash Value Benefit." A disability policy may contain a "return of premium" or "cash value benefit" so long as the insurer demonstrates that the reserve basis for such policies is adequate.

—E. Hospital Indemnity. Policies providing hospital confinement indemnity coverage may not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

—F. Limitations or Exclusions. No policy may limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

- 1. Preexisting conditions or diseases;
- 2. Mental or emotional disorders;
- 3. Alcoholism or drug addiction;
- 4. Pregnancy, but policies may not exclude complications of pregnancy;

— 5. Illness, treatment or medical condition arising out of:

- a. War or act of war, whether declared or undeclared; participation in a felony, riot or insurrection; service in the armed forces or units auxiliary thereto;
- b. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;
- c. Aviation;
- d. Inter-scholastic sports, but only with respect to nonrenewable policies with a term of fewer than six months;

— 6. Cosmetic surgery, but policies may not exclude:

- a. Reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; or
- b. Reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;

— 7. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

— 8. Benefits for the following:

- a. Treatment provided in a government hospital, but this exclusion may not apply to Hospital Confinement Indemnity Coverage, as defined in Subsection R590-126-7(E);
- b. Services performed by a member of the covered person's immediate family;
- c. Services for which no charge is normally made in the absence of insurance; or
- d. Duplication of benefits paid under:
 - i. Medicare or other governmental program (except Medicaid); or
 - ii. Any state or federal worker's compensation, employer's liability or occupational disease law, or any motor vehicle no-fault coverage;

— 9. Dental care or treatment;

— 10. Corrective lenses, and examination for the prescription or fitting thereof, but policies may not exclude required lens implants following cataract surgery;

— 11. Hearing aids, and examination for the prescription or fitting thereof;

— 12. Rest cures;

— 13. Custodial care, except for long-term Care policies;

— 14. Transportation;

— 15. Routine physical examinations;

— 16. Territorial limitations outside the United States.

— 17. Others as may be approved by the commissioner.

— G. Waivers:

- 1. No waiver may be used to exclude, limit, or reduce coverage or benefits unless:
 - a. Acceptance of the waiver is signed by the insured; or
 - b. The full text of the waiver, or a notice thereof, is contained on the first page or specification page of the policy.

— H. Medicare Compliance. Except as otherwise provided in Subsection R590-126-6(L), the terms "Medicare Supplement," "Supplement to Medicare," "Medigap," and words of similar import may not be used unless the policy is issued in compliance with this rule and rule R590-146.

R590-126-6. Disclosure Requirements.

— A. Coverage Description Statement. Each policy subject to this rule shall contain a statement, on the first page or specification

page of the policy, which clearly identifies the type(s) of coverage offered.

— B. Renewal or Nonrenewal Provisions. Each policy or contract subject to this rule shall include a renewal, continuation, or nonrenewal provision. The language or specifications of such provision shall be consistent with the type of contract issued. Such provision shall be appropriately captioned, shall appear on the first page, or schedule page, of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

— C. Rider or Endorsement Acceptance. Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the increased benefit or coverage is required by law.

— D. Premium, Additional. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

— E. Benefit Payment Standard. A policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

— F. Preexisting Conditions. If a policy contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

— G. Accident Only Disclosure. All accident only policies shall contain a prominent statement on the first page of the policy, or attached thereto, in either contrasting color or in boldface type at least equal to the size of type used for policy captions, as follows: "This is an accident only policy and it does not pay benefits for loss from sickness."

— H. Age Limitation. If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact shall be prominently set forth in the outline of coverage and on the schedule page of the policy. However, benefits may not be reduced below levels otherwise required by this rule.

— I. Conversion Privilege. If a policy contains a conversion privilege, it shall comply, in substance, with the following:

— 1. The caption of the provision shall be "Conversion Privilege," or words of similar import;

— 2. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised.

— 3. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

~~—J. Specified Disease Insurance Buyer's Guide. Insurers, except direct response insurers, shall give any person applying for specified disease insurance a Buyer's Guide, approved by the commissioner, at the time of application and shall obtain the recipient's written acknowledgment of the guide's delivery. Direct response insurers shall provide the Buyer's Guide upon request but not later than the time the policy is delivered.~~

~~—K. Specified Disease Insurance Disclosure. All specified-disease policies shall contain a prominent statement on the first page or schedule page of the policy or attached thereto in either contrasting color or in boldface type at least equal to the size type used for policy captions, a prominent statement as follows: "CAUTION: This is a limited policy. Read it carefully with the outline of coverage and the Buyer's Guide."~~

~~—L. Notice Regarding Policies or Subscriber Contracts Which Are Not Medicare Supplement Policies. Any policy or subscriber contract, other than a Medicare Supplement policy, a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act, 42 U.S.C. Section 1395, et seq., or a Disability Income policy, which is issued for delivery to a person eligible by reason of age for Medicare, shall notify insureds under the policy or subscriber contract that the policy or subscriber contract is not a Medicare Supplement policy. Such notice shall either be printed on or attached to the first page of the outline of coverage delivered to insureds under the policy or subscriber contract, or if no outline of coverage is delivered, to the first page of the policy, certificate or subscriber contract delivered to insureds. Such notice shall be in no less than 12 point type and shall contain the following language:~~

~~"THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY OR CONTRACT. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company."~~

~~—M. Medicare Supplement Buyer's Guide. Insurers issuing policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis other than incidentally, to persons eligible for Medicare by reason of age, shall provide to the applicant a Medicare Supplement Buyer's Guide, in a form approved by the commissioner and entitled "Guide to Health Insurance For People With Medicare." Delivery of the Buyer's Guide shall be made whether or not the policy qualifies as a "Medicare Supplement Coverage" according to this rule or Rule R590-146. Except in the case of direct response insurers, delivery of the Buyer's Guide shall be made at the time of application and acknowledgment of receipt or certification of delivery of the Buyer's Guide shall be obtained by the insurer. Direct response insurers shall deliver the Buyer's Guide upon request but not later than at the time the policy is delivered.~~

~~—N. Emergency Care Limitation. A policy which limits treatment in an emergency room or similar facility shall disclose the existence of the limitation in the outline of coverage and on the schedule page of the policy.~~

R590-126-7. Disability, Minimum Standards for Benefits.

~~—A. The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections R590-126-7(C) through (K). A policy or contract subject to this rule which does not meet the required minimum standards contained herein may not be delivered or issued for delivery in this state.~~

~~—B. Exception: A noneonforming policy may be issued only:~~

~~—1. Upon approval by the commissioner as Limited Benefit Health Insurance under Subsection R590-126-7(K), and~~

~~—2. With an Outline of Coverage which complies with the terms of Subsection R590-126-8(K) of this rule.~~

~~—C. Basic Hospital Expense Coverage. This is a policy of disability insurance which provides coverage for a period of not fewer than 31 days during any continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:~~

~~—1. Daily hospital room and board in an amount not less than 70% of the usual and customary charges for semiprivate room accommodations;~~

~~—2. Miscellaneous hospital services for expenses incurred for charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than 70% of the charges incurred or ten times the daily hospital room and board benefits, whichever is less; and~~

~~—3. Hospital outpatient services consisting of:~~

~~—a. Hospital services on the day surgery is performed;~~

~~—b. Hospital services rendered within 72 hours after accidental injury, in an amount not less than \$200 per accident;~~

~~—c. X ray and laboratory tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital to an extent not less than \$200.~~

~~—4. Benefits provided under (1) and (2) of R590-126-7(C) above, may be provided subject to a combined deductible amount not in excess of \$200.~~

~~—D. Basic Medical Surgical Expense Coverage. This is a policy of disability insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:~~

~~—1. Surgical services, of not less than 70% of the usual, reasonable and customary charges.~~

~~—2. Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service, rendered by a physician other than the physician or his assistant performing the surgical services, in an amount not less than the lesser of:~~

~~—a. 70% of the reasonable charges; or~~

~~—b. 15% of the surgical service benefit.~~

~~—3. In hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than 70% of the reasonable charges for not fewer than 31 days during one period of confinement.~~

~~—E. Hospital Confinement Indemnity Coverage. This is a policy of disability insurance which provides daily benefits for hospital confinement on an indemnity basis in an amount not less than \$30 per day and for a period of not fewer than 31 days during any one period of confinement for each person insured under the policy.~~

~~—F. Major Medical Expense Coverage. This is a disability insurance policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than \$25,000; copayment by the covered person not to exceed 30% of covered charges or up to five per cent of the aggregate maximum limit under the policy; an annual deductible stated on a per person, per family, or per calendar or policy year basis, or a combination of~~

such bases not to exceed five per cent of the aggregate maximum limit under the policy. Benefits for each covered person shall be at least:

— 1. Daily hospital room and board expenses in an amount not less than 70% of the semiprivate room rate in the area where the insured resides, for a period of not fewer than 31 days during continuous hospital confinement;

— 2. Miscellaneous hospital services in an amount not less than 20 times the daily room and board rate;

— 3. Surgical services in an amount not less than 70% of the usual, reasonable and customary charges;

— 4. Anesthesia services in an amount not less than 15% of the covered surgical fees;

— 5. In hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required.

— 6. Out of hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, and diagnostic x ray, laboratory services, radiation therapy, chemotherapy, and hemodialysis ordered by a physician; and

— 7. Not fewer than three of the following additional benefits, for an aggregate maximum of such covered charges of not less than \$2,500:

— a. Private duty nursing services;

— b. Nursing home care;

— c. Physiotherapy;

— d. Rental of special medical equipment, as defined by the insurer in the policy;

— e. Prosthetic devices, casts, splints, trusses or braces;

— f. Treatment for functional nervous disorders, and mental and emotional disorders; or

— g. Out of hospital prescription drugs and prescription medications.

— G. Disability Income Protection Coverage. This is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof which:

— 1. Provides that periodic payments which are payable at ages after 62 and reduced solely on the basis of age are at least 50% of amounts payable immediately prior to 62.

— 2. Contains an elimination period no greater than:

— a. In the case of a coverage providing a benefit of one year or less, 90 days;

— b. In all other cases, 365 days.

— 3. Is payable during disability for at least six months, except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period may be for one month.

— 4. Does not reduce benefits because of an increase in Social Security or similar benefits during a benefit period.

— 5. The provisions of this Subsection R590-126-7(G) do not apply to policies providing business buyout coverage.

— H. Accident Only Coverage. This is a policy of accident insurance which provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least \$1,000 and a single dismemberment amount shall be at least \$500.

— I. Specified Accident and Specified Disease Coverage.

— 1. "Specified Accident Coverage" is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment, combined with a benefit amount not less than \$1,000 for accidental death, \$1,000 for double dismemberment and \$500 for single dismemberment.

— 2. "Specified Disease Coverage" pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Any such policy shall meet the general rules set forth in Subsection R590-126-7(1)(2)(a). The policy shall also meet the minimum standards set forth in the applicable Subsections R590-126-7(1)(2)(b), (c), or (d).

— a. General Rules. The following rules apply to specified disease coverage in addition to all other rules imposed by this rule. In cases of conflict with other rules, the following shall govern:

— i. Preexisting Conditions. A specified disease policy, regardless of whether the basis of issuance is a detailed application form, a simplified application form, or an enrollment form, may not deny a claim for loss which occurs more than six months after the effective date of coverage due to a preexisting condition. Such policy may not define a preexisting condition more restrictively than a condition which first manifested itself within six months prior to the effective date of coverage or which was diagnosed by a physician at any time prior to the effective date of coverage.

— ii. Policy Designation. Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this section.

— iii. Medical Diagnosis. Any policy issued pursuant to this section which conditions payment upon pathological diagnosis of a covered disease, shall also provide that if a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted.

— iv. Related Conditions. Notwithstanding any other provision of this rule, specified disease policies shall provide benefits to any covered person not only for the specified disease(s) but also for any other condition(s) or disease(s) directly caused or aggravated by the specified disease(s) or the treatment of the specified disease(s).

— v. Renewability. Specified disease coverage shall be at least Guaranteed Renewable.

— vi. Probationary Period. No policy issued pursuant to Subsection R590-126-7(I) may contain either an elimination or a probationary period greater than 30 days.

— vii. Medicaid Disclaimer. Any application for specified disease coverage shall contain a statement above the signature of the applicant that no person to be covered for specified disease is also covered by any Title XIX program, designated as Medicaid or any similar name. Such statement may be combined with any other statement for which the insurer may require the applicant's signature.

— viii. Medical Care and Charges. Payments may be conditioned upon a covered person receiving medically necessary care, prescribed by a physician, given in a medically appropriate location, under a medically accepted Plan of Care. Payment may be limited to amounts not in excess of usual and customary charges.

— ix. Other Insurance. Benefits for specified disease coverage shall be paid regardless of other coverage.

— x. Retroactive Application of Coverage. After the effective date of the coverage, or the conclusion of an applicable waiting period, if any, subject to Subsection R590-126-7(1)(2)(a)(vi), benefits shall begin with the first day of care or confinement, if such

care or confinement is for a covered disease, even though the diagnosis is made at some later date.

— b. ~~Minimum Expense Incurred Benefits.~~ The following minimum benefit standards apply to specified disease coverage on an expense incurred basis:

— i. ~~Policy Limits.~~ A deductible amount not to exceed \$250, an aggregate benefit limit of not less than \$25,000 and a benefit period of not fewer than three years.

— ii. ~~Copayment.~~ Covered services provided on an outpatient basis may be subject to a copayment which may not exceed 20%.

— iii. ~~Covered Services.~~ Covered services shall include the following:

— (A) ~~Hospital room and board and any other hospital furnished medical services or supplies;~~

— (B) ~~Treatment by, or under the direction of, a legally qualified physician or surgeon;~~

— (C) ~~Private duty nursing services of a Registered Nurse (R.N.), or Licensed Practical Nurse (L.P.N.);~~

— (D) ~~X ray, radium, chemotherapy and other therapy procedures used in diagnosis and treatment;~~

— (E) ~~Blood transfusions, and the administration thereof, including expense incurred for blood donors;~~

— (F) ~~Drugs and medicines prescribed by a physician;~~

— (G) ~~Professional ambulance for local service to or from a local hospital;~~

— (H) ~~The rental of any respiratory or other mechanical apparatuses;~~

— (I) ~~Braces, crutches and wheelchairs as are deemed necessary by the attending physician for the treatment of the disease;~~

— (J) ~~Emergency transportation if, in the opinion of the attending physician, it is necessary to transport the insured to another locality for treatment of the disease;~~

— (K) ~~Home Health Care, as defined in Subsection R590-126-3(A)(14), which is provided by, or under the direction of, a Home Health Agency. The Plan of Care shall be prescribed in writing.~~

— (L) ~~Physical, speech, hearing and occupational therapy;~~

— (M) ~~Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and ileostomy appliances;~~

— (N) ~~Prosthetic devices including wigs and artificial breasts; and~~

— (O) ~~Nursing Home care for noncustodial services.~~

— c. ~~Minimum Per Diem Benefits.~~ The following minimum benefit standards apply to coverages written on a per diem indemnity basis:

— i. ~~Hospital Confinement Benefit.~~ A fixed sum payment of at least \$200 for each day of hospital confinement for at least 365 days, with no deductible amount permitted;

— ii. ~~Outpatient Benefit.~~ A fixed sum payment equal to one half the hospital inpatient benefits for each day of hospital or nonhospital outpatient surgery, radiation therapy and chemotherapy, for at least 365 days of treatment.

— iii. ~~Nursing Home/Home Health Care Benefit.~~ Benefits tied to confinement in a Nursing Home or to receipt of Home Health Care are optional; if a policy offers these benefits, they must equal the following:

— (A) ~~A fixed sum payment equal to one half the hospital inpatient benefit for each day of Skilled Nursing Home confinement for at least 100 days.~~

— (B) ~~A fixed sum payment equal to one fourth the hospital inpatient benefit for each day of Home Health Care for at least 180 days.~~

— (C) ~~Notwithstanding any other provision of this rule, any restriction or limitation applied to the benefits in the above Subsections R590-126-7(I)(2)(e)(iii)(A) and ((B)), whether by definition or otherwise, may not be more restrictive than those under Medicare.~~

— d. ~~Principal Sum Benefits.~~ The following minimum benefit standards apply to principal sum indemnity coverage of any specified disease(s):

— i. ~~Benefits shall be payable as a fixed, one-time payment made within 30 days of submission to the insurer of proof of diagnosis of the specified disease(s). Dollar benefits shall be offered for sale only in even increments of \$1,000.~~

— ii. ~~Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases (e.g., "cancer insurance," "heart disease insurance"), the same dollar amounts shall be payable regardless of the particular subtype of the disease (e.g., lung or bone cancer), with one exception. In the case of clearly identifiable subtypes with significantly lower treatment costs (e.g., skin cancer), lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits.~~

— J. ~~Catastrophic Coverage.~~ This is a policy of disability insurance which:

— 1. ~~provides benefits for medical expenses incurred by the insured to an aggregate maximum of not less than \$1,000,000;~~

— 2. ~~contains no separate internal dollar limits;~~

— 3. ~~may be subject to a policy deductible which does not exceed the greater of .01% of the policy limit or the amount of other disability insurance coverage for the same medical expenses; and~~

— 4. ~~contains no percentage participation or coinsurance clause for expenses which exceed the deductible.~~

— K. ~~Limited Benefit Health Insurance Coverage.~~ This is any policy or contract other than a policy or contract covering only a specified disease or diseases which provides benefits that are less than the minimum standards for benefits required under Subsections R590-126-7(C), (D), (E), (F), (G), (H), (I) and (J). Such policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage provided by Subsection R590-126-8(K) of this rule is completed and delivered as required by Subsection R590-126-8(A) of this rule. A policy covering a single specified disease or combination of diseases shall meet the requirements of Subsection R590-126-7(I) and may not be offered for sale as a "Limited Coverage" under this section. This subsection does not apply to policies designed to provide coverage for Long Term Care, as governed by Rule R590-148, or Medicare Supplement, as governed by R590-146.

R590-126-8. Disability, Outlines of Coverage.

— A. ~~Outline of Coverage Requirements.~~

— 1. ~~No policy or contract subject to this rule may be delivered or issued for delivery in this state unless an appropriate outline of coverage, as prescribed in Subsections R590-126-8(C) through (L), is completed and delivered to the applicant at the time application is made, with acknowledgement of receipt or certification of delivery provided to the insurer, or is delivered with the policy. In the case of direct response solicitation, the outline of coverage shall be delivered upon request, but no later than the time the policy is delivered.~~

—2. ~~Substitute Outline.~~ If an outline of coverage was delivered at the time of application and the policy or contract is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or contract shall accompany the policy or contract when it is delivered and contain the following statement, in no less than 12 point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

—3. ~~Changes in Outline.~~ Appropriate changes in terminology may be made in the outline of coverage in the case of contracts of hospital, medical, or dental service corporations. In any other case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or contract, an alternate outline of coverage shall be submitted to the commissioner for prior approval.

—4. ~~Outlines of Coverage for Combined Coverages.~~ The outlines of coverage designated in Subsections R590-126-8(A)(4)(a) and (b) herein shall be appropriate for policies offering the combination coverages as listed:

—a. ~~Basic Hospital and Medical Surgical Expense Outline (Outline (L)).~~ The following combination coverages are included:

—i. ~~Basic Hospital Expense (Coverage (C)) and Basic Medical-Surgical Expense Coverage (Coverage (D)).~~

—b. ~~Major Medical Expense Outline (Outline (F)).~~ The following combination coverages may be included:

—i. ~~Basic Hospital Expense (Coverage (C)) and Major Medical Expense Coverage (Coverage (F)); or~~

—ii. ~~Basic Medical-Surgical Expense (Coverage (D)) and Major Medical Expense Coverage (Coverage (F)); or~~

—iii. ~~Basic Hospital Expense (Coverage (C)), Basic Medical-Surgical Expense (Coverage (D)), and Major Medical Expense Coverage (Coverage (F)).~~

—B. ~~Outlines of Coverage Required; Sample Provisions.~~ Insurance transacted under the provisions of this rule shall be disclosed as provided by this Section. Disclosure of the coverages listed in Subsections R590-126-7(C) through (K) shall include an Outline of Coverage which meets the requirements of the following corresponding Subsections R590-126-8(C) through (K), or an outline for a combination of coverages which meets the requirements of Subsection R590-126-8(A)(4) and either Subsection R590-126-8(F) or (L). These outlines are available from the Utah Insurance Department.

—C. ~~Basic Hospital Expense Coverage (Outline of Coverage).~~ An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(C) of this rule. The items included in the outline of coverage shall appear in the sequence prescribed: (Company Name) ~~Basic Hospital Expense Coverage Outline of Coverage~~

—1. ~~Read Your Policy Carefully.~~ This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you ~~READ YOUR POLICY CAREFULLY!~~

—2. ~~Basic Hospital Expense Coverage.~~ Policies of this category are designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, and hospital outpatient services,

subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physician's or surgeon's fees or unlimited hospital expenses.

—3. ~~A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:~~

—a. ~~Daily hospital room and board;~~

—b. ~~Miscellaneous hospital services;~~

—c. ~~Hospital outpatient services;~~

—d. ~~Other benefits, if any;~~

—e. ~~The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.~~

—4. ~~A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.~~

—5. ~~A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.~~

—D. ~~Basic Medical Surgical Expense Coverage (Outline of Coverage).~~ An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(D) of this rule. The items included in the outline of coverage shall appear in the sequence prescribed:

—(Company Name) ~~Basic Medical Surgical Expense Coverage Outline of Coverage~~

—1. ~~Read Your Policy Carefully.~~ This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you ~~READ YOUR POLICY CAREFULLY!~~

—2. ~~Basic Medical Surgical Expense Coverage.~~ Policies of this category are designed to provide, to persons insured, coverage for medical surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical surgical expenses.

—3. ~~A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:~~

—a. ~~Surgical services;~~

—b. ~~Anesthesia services;~~

—c. ~~In hospital medical services;~~

—d. ~~Other benefits, if any;~~

—e. ~~The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.~~

—4. ~~A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.~~

—5. ~~A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.~~

—E. ~~Hospital Confinement Indemnity Coverage (Outline of Coverage).~~ An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of

Subsection R590-126-7(E) of this rule. The items included in the outline of coverage shall appear in the sequence prescribed:

— (Company Name) Hospital Confinement Indemnity Coverage Outline of Coverage

— 1. Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

— 2. Hospital Confinement Indemnity Coverage. Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

— 3. A brief specific description of the benefits contained in this policy in the following order:

- a. Daily benefit payable during hospital confinement;
- b. Duration of such benefit described in (a), above.
- c. The above description of benefits shall be stated clearly and concisely.

— 4. A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefit, described in (3) above.

— 5. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

— 6. Any benefits provided in addition to the daily hospital benefit.

— F. Major Medical Expense Coverage (Outline of Coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(F) of this rule. An outline of coverage which meets these requirements shall also be issued in connection with a policy insuring a combination of the coverages under policies meeting the standards of Subsections R590-126-7(C) and (F), (D) and (F), or (C), (D) and (F), in accordance with the requirements of Subsection R590-126-8(A)(4). The items included in the outline of coverage shall appear in the sequence prescribed:

— (Company Name) Major Medical Expense Coverage Outline of Coverage

— 1. Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

— 2. Major Medical Expense Coverage. Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided in this policy. (Note: If basic hospital and/or basic medical insurance

coverage is provided, the inappropriate part of the last sentence may be omitted.)

— 3. A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:

- a. Daily hospital room and board;
- b. Miscellaneous hospital services;
- c. Surgical services;
- d. Anesthesia services;
- e. In-hospital medical services;
- f. Out-of-hospital care;
- g. Maximum dollar amount for covered charges;
- h. Other benefits, if any;
- i. The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.

— 4. A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.

— 5. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

— G. Disability Income Protection Coverage (Outline of Coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(G) of this rule. The items included in the outline of coverage shall appear in the sequence prescribed:

— (Company Name) Disability Income Protection Coverage Outline of Coverage

— 1. Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

— 2. Disability Income Protection Coverage. Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical surgical, or major medical expenses.

— 3. A brief specific description of benefits shall be stated clearly and concisely.

— 4. A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.

— 5. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

— H. Accident Only Coverage (Outline of Coverage). An outline of coverage in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(H) of this rule. The items included in the outline of coverage shall appear in the sequence prescribed:

— (Company Name) Accident Only Coverage Outline of Coverage

— 1. Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It

is, therefore, important that you ~~READ YOUR POLICY CAREFULLY!~~

~~—2. Accident Only Coverage. Policies of this category are designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.~~

~~—3. A brief specific description of the benefits contained in this policy. The description shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with Subsection R590-126-4(M) of this rule.~~

~~—4. A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.~~

~~—5. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.~~

~~—I. Specified Accident or Specified Disease Coverage (Outline of Coverage). An outline of coverage in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(I) of this rule. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage shall appear in the sequence prescribed:~~

~~—(Company Name) (Specified Accident) (Specified Disease) Coverage Outline of Coverage~~

~~—1. This policy is designed only as a supplement for a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. It should not be purchased by persons covered under Medicaid. Read the Buyer's Guide discussion of the possible limits on benefits in this type of policy.~~

~~—2. Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!~~

~~—3. (Specified Accident) (Specified Disease) Coverage. Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified accidents or specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expense.~~

~~—4. A brief specific description of the benefits, including dollar amounts, contained in this policy. The description shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with Subsection R590-126-4(M) of this rule.~~

~~—5. A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (4) above.~~

~~—6. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.~~

~~—J. Catastrophic Coverage. An outline of coverage, in the form prescribed below, shall be issued in connection with policies~~

~~meeting the standards of Subsection R590-126-7(J) of this rule. The items included in the outline of coverage shall appear in the sequence prescribed:~~

~~—(Company Name) Catastrophic Coverage Outline of Coverage~~

~~—1. Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!~~

~~—2. Catastrophic Coverage. Policies of this category are designed to provide, to persons insured, catastrophic coverage for losses resulting from a covered accident or sickness, subject to any limitations set forth in the policy.~~

~~—3. A brief specific description of benefits shall be stated clearly and concisely.~~

~~—4. A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.~~

~~—5. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.~~

~~—K. Limited Benefit Health Coverage (Outline of Coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies which do not meet the minimum standards of Section R590-126-7. The items included in the outline of coverage shall appear in the sequence prescribed:~~

~~—(Company Name) Limited Benefit Health Coverage Outline of Coverage~~

~~—1. Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!~~

~~—2. Limited Benefit Health Coverage. Policies of this category are designed to provide, to persons insured, LIMITED OR SUPPLEMENTAL coverage.~~

~~—3. A brief specific description of the benefits, including dollar amounts, contained in this policy. The description shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with Subsection R590-126-4(M) of this rule.~~

~~—4. A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.~~

~~—5. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.~~

~~—L. Basic Hospital and Medical Surgical Expense Coverage (Outline of Coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsections R590-126-7(C) and (D) of this rule. The items included in the outline of coverage shall appear in the sequence prescribed:~~

~~—(Company Name) Basic Hospital and Medical Surgical Expense Coverage Outline of Coverage~~

~~—1. Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!~~

~~—2. Basic Hospital and Medical Surgical Expense Coverage. Policies of this category are designed to provide, to persons insured, coverage for hospital and medical surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical surgical expenses.~~

~~—3. A brief specific description of the benefits including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:~~

- ~~— a. Daily hospital room and board;~~
- ~~— b. Miscellaneous hospital services;~~
- ~~— c. Hospital outpatient services;~~
- ~~— d. Surgical services;~~
- ~~— e. Anesthesia services;~~
- ~~— f. In hospital medical services;~~
- ~~— g. Other benefits, if any;~~

~~— h. The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.~~

~~—4. A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any manner operate to qualify payment of the benefits described in (3) above.~~

~~—5. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.~~

R590-126-9. Disability, Requirements for Replacement.

~~—A. Application Information. Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other disability policy or certificate presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.~~

~~—B. Notice to Existing Insurer. Where replacement is involved, the replacing insurer shall notify by written communication the existing insurer of the proposed replacement. Such existing insurance shall be identified by the name of the insurer, name of insured, and insured's address or contract number. The written communication shall be made within five working days of the date the application is received in the replacing insurer's home or regional office or the date the proposed policy or contract is issued, whichever is sooner.~~

~~—C. Notice to Applicant.~~

~~—1. Nondirect Response. Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the policy or certificate, the notice described in R590-126-9(D) below. One copy of such notice shall be retained by the applicant and an additional copy, signed by the applicant, shall be retained by the insurer.~~

~~—2. Direct Response. A direct response insurer shall deliver to the applicant, upon issuance of the policy or certificate, the notice described in R590-126-9(E) below.~~

~~—D. Nondirect Response Notice Form. The notice required by Subsection R590-126-9(C)(1) above for an insurer, other than a direct response insurer, shall be in substantially the following form: "NOTICE TO APPLICANT REGARDING REPLACEMENT OF DISABILITY INSURANCE"~~

~~—1. According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing insurance and replace it with a policy to be issued by (insert Company Name) Insurance Company. Your new policy provides (insert number of days) within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.~~

~~— a. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.~~

~~— b. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.~~

~~— c. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history.~~

~~— d. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.~~

~~— e. The above "Notice to Applicant" was delivered to me on ... (Date) ...; ... (Signature) ...~~

~~—E. Direct Response Notice Form. The notice required by Subsection R590-126-9(C)(2) above for a direct response insurer shall be in substantially the following form: "NOTICE TO APPLICANT REGARDING REPLACEMENT OF DISABILITY INSURANCE"~~

~~—1. According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing disability insurance and replace it with the policy delivered herewith issued by (insert Company Name) Insurance Company. Your new policy provides (insert number of days) within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.~~

~~— a. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.~~

~~— b. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest~~

to make sure you understand all the relevant factors involved in replacing your present coverage.

e. (To be included only if the application is attached to the policy). If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (insert company name and address) within the time allowed if any information is not correct and complete, or if any past medical history has been left out of the application.

F. Exception. The notices described in this section will not be required in the solicitation of accident only or single premium nonrenewable policies.

R590-126-10. Penalties.

Persons found, after hearing or other acceptable process, to be in violation of this rule shall be subject to penalties as provided under Section 31A-2-308, U.C.A.

R590-126-11. Severability.

If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances may not be affected thereby.

KEY: insurance law

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Notice of Continuation February 1, 2002

~~31A-2-201~~

~~31A-2-202~~

~~31A-21-101~~

~~31A-21-201~~

~~31A-22-605~~

~~31A-23-302~~

~~31A-23-312~~

~~31A-26-301]~~

R590-126. Accident and Health Insurance Standards.

R590-126-1. Authority.

This rule is issued by the insurance commissioner pursuant to the following provisions of the Utah Insurance Code:

(1) Subsection 31A-2-201(3)(a) authorizes rules to implement the Insurance Code;

(2) Sections 31A-2-202 and 31A-23a-412 authorize the commissioner to request reports, conduct examinations, and inspect records of any licensee;

(3) Subsection 31A-22-605(4) requires the commissioner to adopt rules to establish standards for disclosure in the sale of, and benefits to be provided by individual and franchise accident and health policies;

(4) Section 31A-22-623 authorizes the commissioner to establish by rule minimum standards of coverage for dietary products of inborn metabolic errors;

(5) Section 31A-22-626 authorizes the commissioner to establish by rule minimum standards of coverage for diabetes accident and health insurance;

(6) Subsection 31A-23a-402(8) authorizes the commissioner to define by rule acts and practices that are unfair and unreasonable; and

(7) Subsection 31A-26-301(1) authorizes the commissioner to set standards for timely payment of claims.

R590-126-2. Purpose and Scope.

(1) Purpose. The purpose of this rule is to provide reasonable standardization and simplification of terms and coverages of insurance policies in order to facilitate public understanding and comparison and to prohibit provisions which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of such insurance.

(2) Scope.

(a) This regulation applies to:

(i) all individual accident and sickness insurance policies and group supplemental health policies and certificates, delivered or issued for delivery in this state on and after January 1, 2006, that are not specifically exempted from this regulation, regardless of:

(A) whether the policy is issued to an association; a trust; a discretionary group; or other similar grouping; or

(B) the situs of delivery of the policy or contract; and

(ii) all dental plans and vision plans.

(b) This rule shall not apply to:

(i) employer accident and health insurance, as defined in Section 31A-22-502;

(ii) policies issued to employees or members as additions to franchise plans in existence on the effective date of this regulation;

(iii) Medicare supplement policies subject to Section 31A-22-620; or

(iv) civilian Health and Medical Program of the Uniformed Services, Chapter 55, title 10 of the United States Code, CHAMPUS supplement insurance policies.

(3) The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted.

R590-126-3. Definitions.

In addition to the definitions of Section 31A-1-301 and Subsection 31A-22-605(2), the following definitions shall apply for the purpose of this rule.

(1) "Accident," "accidental injury," and "accidental means" shall be defined to employ result language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(a) The definition shall not be more restrictive than the following: "injury" or "injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause and that occurs while the insurance is in force.

(b) Unless otherwise prohibited by law, the definition may exclude injuries for which benefits are paid under worker's compensation, any employer's liability or similar law, or a motor vehicle no-fault plan.

(2) "Adult Day Care" shall mean a facility duly licensed and operating within the scope of such license. Adult Day Care facility may not be defined more restrictively than providing continuous care and supervision for three or more adults 18 years of age and over for at least four but less than 24 hours a day, that meets the needs of functionally impaired adults through a comprehensive program that provides a variety of health, social, recreational, and related support services in a protective setting.

(3) "Certificate of Completion" shall mean a document issued by the Utah Board of Education to a person who completes an approved course of study not leading to a diploma, or to one who passes a challenge for that same course of study, or to one whose out-of-state credentials and certificate are acceptable to the Board.

(4) "Complications of Pregnancy" shall mean diseases or conditions the diagnoses of which are distinct from pregnancy but are adversely affected or caused by pregnancy and not associated with a normal pregnancy.

(a) "Complications of Pregnancy" include acute nephritis, nephrosis, cardiac decompensation, ectopic pregnancy which is terminated, a spontaneous termination of pregnancy when a viable birth is not possible, puerperal infection, eclampsia, pre-eclampsia and toxemia.

(b) This definition does not include false labor, occasional spotting, doctor prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy.

(5) "Conditionally Renewable" means renewal can be declined by class, by geographic area or for stated reasons other than deterioration of health.

(6) "Convalescent Nursing Home," "extended care facility," or "skilled nursing facility" shall mean a facility duly licensed and operating within the scope of such license.

(7) "Cosmetic Surgery" or "Reconstructive Surgery" shall mean any surgical procedure performed primarily to improve physical appearance.

(a) This definition does not include surgery, which is necessary:

(i) to correct damage caused by injury or sickness;

(ii) for reconstructive treatment following medically necessary surgery;

(iii) to provide or restore normal bodily function; or

(iv) to correct a congenital disorder that has resulted in a functional defect.

(b) This provision does not require coverage for preexisting conditions otherwise excluded.

(8) "Custodial Care" shall mean a Plan of Care, which does not provide treatment for sickness or injury, but is only for the purpose of meeting personal needs and maintaining physical condition when there is no prospect of effecting remission or restoration of the patient to a condition in which care would not be required. Such care may be provided by persons without nursing skills or qualifications. If a nursing care facility is only providing custodial or residential care, the level of care may be so characterized.

(9) "Disability Income" shall mean income replacement as defined in Section 31A-1-301.

(10) "Elimination Period" or "Waiting Period" means the length of time an insured shall wait before benefits are paid under the policy.

(11) "Enrollment Form" shall mean application as defined in Section 31A-1-301.

(12) "Experimental Treatment" is defined as medical treatment, services, supplies, medications, drugs, or other methods of therapy or medical practices which are not accepted as a valid course of treatment by the Utah Medical Association, the U.S. Food and Drug Administration, the American Medical Association, or the Surgeon General.

(13) "Group Supplemental Health Insurance" means group accident and sickness insurance policies and certificates providing

hospital confinement indemnity, accident only, specified disease, specified accident or limited benefit health coverage.

(14) "Guaranteed Renewable" means renewal cannot be declined by the insurance company for any reasons, but the insurance company can revise rates on a class basis.

(15) "Home Health Agency" shall mean a public agency or private organization, or subdivision of a health care facility, licensed and operating within the scope of such license.

(16) "Home Health Aide" shall mean a person who obtains a Certificate of Completion, as required by law, which allows performance of health care and other related services under the supervision of a registered nurse from the home health agency, or performance of simple procedures as an extension of physical, speech, or occupational therapy under the supervision of licensed therapists.

(17) "Home Health Care" shall mean services provided by a home health agency.

(18) "Homemaker" shall mean a person who cares for the environment in the home through performance of duties such as housekeeping, meal planning and preparation, laundry, shopping and errands.

(19) "Homemaker/Home Health Aide" shall mean a person who has obtained a Certificate of Completion, as required by law, which allows performance of both homemaker and home health aide services, and who provides health care and other related services under the supervision of a registered nurse from the home health agency or under the supervision of licensed therapists.

(20) "Hospice" shall mean a program of care for the terminally ill and their families which occurs in a home or in a health care facility and which provides medical, palliative, psychological, spiritual, or supportive care and treatment and is licensed and operating within the scope of such license.

(21) "Hospital" means a facility that is licensed and operating within the scope of such license. This definition may not preclude the requirement of medical necessity of hospital confinement or other treatment.

(22) "Intermediate Nursing Care" shall mean nursing services provided by, or under the supervision of, a registered nurse. Such care shall be for the purpose of treating the condition for which confinement is required.

(23) "Medical Necessity" means:

(a) health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

(i) in accordance with generally accepted standards of medical practice in the United States;

(ii) clinically appropriate in terms of type, frequency, extent, site, and duration;

(iii) not primarily for the convenience of the patient, physician, or other health care provider; and

(iv) covered under the contract;

(b) when a medical question-of-fact exists medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.

(i) For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence.

(ii) For established interventions, the effectiveness shall be based on:

(A) scientific evidence;
(B) professional standards; and
(C) expert opinion.
(24) "Medicare" means the "Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended."
(25) "Medicare Supplement Policy" shall mean an individual, franchise, or group policy of accident and health insurance, other than a policy issued pursuant to a contract under section 1876 of the federal Social Security Act, 42 U.S.C. section 1395 et seq., or an issued policy under a demonstration project specified in 41 U.S.C. section 1395ss(g)(1), that is advertised, marketed, or primarily designed as a supplement to reimbursements under Medicare for hospital, medical, or surgical expenses of persons eligible for Medicare.
(26) "Mental or Nervous Disorders" may not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or any other mental or emotional disease or disorder which does not have a demonstrable organic cause.
(27) "Non-Cancelable" means renewal cannot be declined nor can rates be revised by the insurance company.
(28) "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as registered nurse, or licensed practical nurse. If the words "nurse" or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with applicable statutes or administrative rules.
(29) "Nurse, Licensed Practical" shall mean a person who is registered and licensed to practice as a practical nurse.
(30) "Nurse, Registered" shall mean any person who is registered and licensed to practice as a registered nurse.
(31) "Nursing Care" shall mean assistance provided for the health care needs of sick or disabled individuals, by or under the direction of licensed nursing personnel.
(32) "One Period of Confinement" shall mean consecutive days of in-hospital service received as an inpatient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time of not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy up to a maximum of 180 days.
(33) "Optionally Renewable" means renewal is at the option of the insurance company.
(34) "Partial Disability" shall be defined in relation to the individual's inability to perform one or more, but not all, of: the major, important, or essential duties of employment or occupation; customary duties of a homemaker or dependent; or may be related to a percentage of time worked or to a specified number of hours or to compensation.
(35) "Personal Care" shall mean assistance, under a plan of care by a home health agency, provided to persons in activities of daily living.
(36) "Personal Care Aide" shall mean a person who obtains a Certificate of Completion, as required by law, which allows that person to assist in the activities of daily living and emergency first aid, and who must be supervised by a registered nurse from the home health agency.
(37) "Physician" may be defined by including words such as qualified physician or licensed physician. The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and

treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(38) "Preexisting Condition."

(a) Except as provided in Section (b), a preexisting condition shall not be defined more restrictively than the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a two year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a two year period preceding the effective date of the coverage of the insured person.

(b) A specified disease insurance policy shall not define preexisting condition more restrictively than a condition which first manifested itself within six months prior to the effective date of coverage or which was diagnosed by a physician at any time prior to the effective date of coverage.

(39) "Probationary Period" shall mean the period of time following the date of issuance or effective date of the policy before coverage begins for all or certain conditions.

(40) "Residential Health Care Facility" shall mean a publicly or privately operated and maintained facility providing personal care to residents who require protected living arrangements which is licensed and operating within the scope of such license.

(41) "Residual Disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the major, important, or essential duties of employment or occupation, or to the inability to perform all usual duties for as long as is usually required.

(42) "Respite Care" shall mean provision of temporary support to the primary caregiver of the aged, disabled, or handicapped individual insured, by taking over the tasks of that person for a limited period of time. The insured may receive care in the home, or other appropriate community location, or in an appropriate institutional setting.

(43)(a) "Scientific evidence" means:

(i) scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or

(ii) findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.

(b) Scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

(44) "Sickness" means illness, disease, or disorder of an insured person.

(45) "Skilled Nursing Care" shall mean nursing services provided by, or under the supervision of, a registered nurse. Such care shall be for the purpose of treating the condition for which the confinement is required and not for the purpose of providing intermediate or custodial care.

(46) "Therapist" may be defined as a professionally trained or duly licensed or registered person, such as a physical therapist, occupational therapist, or speech therapist, who is skilled in applying treatment techniques and procedures under the general direction of a physician.

(47)(a) "Total Disability" shall mean an individual who:

(i) is not engaged in employment or occupation for which he is or becomes qualified by reason of education, training or experience; and

(ii) is unable to perform all of the substantial and material duties of his or her regular occupation or words of similar import.

(b) An insurer may require care by a physician other than the insured or a member of the insured's immediate family.

(c) The definition may not exclude benefits based on the individual's:

(i) ability to engage in any employment or occupation for wage or profit;

(ii) inability to perform any occupation whatsoever, any occupational duty, or any and every duty of his occupation; or

(iii) inability to engage in any training or rehabilitation program.

(48)(a) "Usual and Customary" shall mean the most common charge for similar services, medicines or supplies within the area in which the charge is incurred.

(b) In determining whether a charge is usual and customary, insurers shall consider one or more of the following factors:

(i) the level of skill, extent of training, and experience required to perform the procedure or service;

(ii) the length of time required to perform the procedure or services as compared to the length of time required to perform other similar services;

(iii) the severity or nature of the illness or injury being treated;

(iv) the amount charged for the same or comparable services, medicines or supplies in the locality; the amount charged for the same or comparable services, medicines or supplies in other parts of the country;

(v) the cost to the provider of providing the service, medicine or supply; and

(vi) other factors determined by the insurer to be appropriate.

(49) "Waiting Period" shall mean "Elimination Period."

R590-126-4. Prohibited Policy Provisions.

(1) Probationary periods.

(a) A policy shall not contain provisions establishing a probationary period during which no coverage is provided under the policy, subject to the further exception that a policy may specify a probationary period not to exceed six months for specified diseases or conditions and losses resulting from disease or condition related to:

(i) adenoids;

(ii) appendix;

(iii) disorder of reproductive organs;

(iv) hernia;

(v) tonsils; and

(vi) varicose veins.

(b) The six-month period in Subsection (1)(a) may not be applicable where such specified diseases or conditions are treated on an emergency basis.

(c) Accident policies may not contain probationary or waiting periods.

(d) A probationary or waiting period for a specified disease policy shall not exceed 30 days.

(2) Preexisting conditions.

(a) Except as provided in Subsections (b) and (c), a policy shall not exclude coverage for a loss due to a preexisting condition for a period greater than 12 months following the issuance of the policy or certificate where the application or enrollment form for the

insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and the preexisting condition is not specifically excluded by the terms of the policy or certificate.

(b) A specified disease policy shall not exclude coverage for a loss due to a preexisting condition for a period greater than six months following the issuance of the policy or certificate, unless the preexisting condition is specifically excluded.

(c) A hospital confinement indemnity policy shall not exclude a preexisting condition for a period greater than 12 months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.

(d) Any preexisting condition elimination period must be reduced by any applicable creditable coverage.

(3) Hospital indemnity. Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

(4) Limitations or exclusions. A policy shall not limit or exclude coverage or benefits by type of illness, accident, treatment or medical condition, except as follows:

(a) abortion;

(b) acupuncture and acupressure services;

(c) administrative charges for completing insurance forms, duplication services, interest, finance charges, or other administrative charges, unless otherwise required by law;

(d) administrative exams and services;

(e) allergy tests and treatments;

(f) aviation;

(g) axillary hyperhidrosis;

(h) benefits provided under:

(A) Medicare or other governmental program, except Medicaid;

(B) state or federal worker's compensation; or

(C) employer's liability or occupational disease law.

(i) cardiopulmonary fitness training, exercise equipment, and membership fees to a spa or health club;

(j) charges for appointments scheduled and not kept;

(k) chiropractic;

(l) complementary and alternative medicine;

(m) corrective lenses, and examination for the prescription or fitting thereof, but policies may not exclude required lens implants following cataract surgery;

(n) cosmetic surgery including gastric bypass; reversal, revision, repair or treatment related to a non-covered cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;

(o) custodial care;

(p) dental care or treatment, except dental plans;

(q) dietary products, except as required by R590-194;

(r) educational and nutritional training, except as required by R590-200;

(s) experimental and/or investigational services;

(t) felony, riot or insurrection, when the insured is a voluntary and active participant;

(u) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of

the feet, including orthotics. The exclusion of routine foot care does not apply to cutting or removal of corns, calluses, or nails when provided to a person who has a systemic disease, such as diabetes with peripheral neuropathy or circulatory insufficiency, of such severity that unskilled performance of the procedure would be hazardous;

(v) gene therapy;
(w) genetic testing;
(x) hearing aids, and examination for the prescription or fitting thereof;

(y) illegal activities, limited to losses related directly to the insured's voluntary participation;

(z) incarceration, with respect to disability income policies;
(aa) infertility services, except as required by R590-76;
(bb) interscholastic sports, with respect to short-term nonrenewable policies;

(cc) mental or emotional disorders, alcoholism and drug addictions;

(dd) motor vehicle no-fault law, except when the covered person is required by law to have no-fault coverage, the exclusion applies to charges up to the minimum coverage required by law whether or not such coverage is in effect;

(ee) nuclear release;
(ff) preexisting conditions or diseases as allowed under Subsection R590-126-4(2), except for coverage of congenital anomalies as required by Section 31A-22-610;

(gg) pregnancy, except for complications of pregnancy;
(hh) refractive eye surgery;
(ii) rehabilitation therapy services (physical, speech, and occupational), unless required to correct an impairment caused by a covered accident or illness;

(jj) respite care;
(kk) rest cures;
(ll) routine physical examinations;
(mm) service in the armed forces or units auxiliary to it;
(nn) services rendered by employees of hospitals, laboratories or other institutions;

(oo) services performed by a member of the covered person's immediate family;

(pp) services for which no charge is normally made in the absence of insurance;

(qq) sexual dysfunction;
(rr) shipping and handling, unless otherwise required by law;
(ss) suicide, sane or insane, attempted suicide, or intentionally self-inflicted injury;

(tt) telephone/electronic consultations;
(uu) territorial limitations outside the United States;

(vv) terrorism, including acts of terrorism;
(ww) transplants;

(xx) transportation;
(yy) treatment provided in a government hospital, except for hospital indemnity policies; or

(zz) war or act of war, whether declared or undeclared.

(5) Waivers. This rule shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required.

(6) Commissioner authority. Policy provisions precluded in this section shall not be construed as a limitation on the authority of

the commissioner to prohibit other policy provisions that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.

R590-126-5. General Requirements.

(1) Policy definitions. No policy subject to this rule may contain definitions respecting the matters defined in Section R590-126-3 unless such definitions comply with the requirements of that section.

(2) Rights of spouse. The following provisions apply to policies that provide coverage to a spouse of the insured:

(a) A policy may not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than for nonpayment of premium.

(b) A policy shall provide that in the event of the insured's death the spouse of the insured shall become the insured.

(c) The age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the noncancellation or renewal provisions of the policy. However, this requirement may not prevent termination of coverage of the older spouse upon attainment of stated age limit in the policy, so long as the policy may be continued in force as to the younger spouse to the age or for durational period as specified in said definition.

(3) Cancellation, Renewability, and Termination. The terms "conditionally renewable," "guaranteed renewable," "noncancellable," or "optionally renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Subsection R590-126-6(2).

(a) Conditionally renewable. The term "conditionally renewable" may be used only in a policy which the insured may have the right to continue in force by the timely payment of premiums at least to age 65, during which period the insurer has no right to make any unilateral change to the detriment of the insured while the policy is in force. However, the insurer, at its option, and by timely notice, may decline renewal for reasons stated in the policy, or may make changes in premium rates by classes.

(b) Guaranteed renewable. The term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums at least to age 65, during which period the insurer has no right to make any unilateral change to the detriment of the insured while the policy is in force, except that the insurer may make changes in premium rates by classes.

(c) Noncancellable. The term "noncancellable" may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of 65, during which period the insurer has no right to make unilaterally any change in any provision of the policy to the detriment of the insured.

(d) Optionally renewable. The term "optionally renewable" may be used only in a policy which the insured may have the right to continue in force by the timely payment of premiums at least to age 65, during which period the insurer has no right to make any unilateral change in any provision of the policy while the policy is in force. However, the insurer, at its option, and by timely notice, may decline renewal of the policy or may make changes in premium rates by classes.

(e) Notice of nonrenewal shall be given 90 days prior to nonrenewal.

(f) A policy may not be cancelled or nonrenewed solely on the grounds of deterioration of health.

(g) Termination of the policy shall be without prejudice to a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.

(4) Optional insureds. When accidental death and dismemberment coverage is part of the accident and health insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.

(5) Military service. If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.

(6) Pregnancy benefit extension. In the event the insurer cancels or refuses to renew a policy providing pregnancy benefits, the policy shall provide an extension of benefits for a pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force. This requirement does not apply to a policy that is canceled for the following reasons:

(a) the insured fails to pay the required premiums in accordance with the terms of the plan; or

(b) the insured person performs an act or practice that constitutes fraud in connection with the coverage or makes an intentional misrepresentation of material fact under the terms of the coverage.

(7) Post hospital admission requirement. A policy providing convalescent or extended care benefits following hospitalization shall not condition the benefits upon admission to the convalescent or extended care facility within a period of less than 14 days after discharge from the hospital.

(8) Transplant donor coverage. A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.

(9) Recurrent disability. A policy may contain a provision relating to recurrent disabilities, but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than 6 months.

(10) Time limit for occurrence of loss.

(a) Accidental death and dismemberment benefits shall be payable if the loss occurs within 180 days from the date of the accident, irrespective of total disability.

(b) Disability income benefits, if provided, shall not require the loss to commence less than 30 days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.

(11) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(12) A policy providing coverage for fractures or dislocations may not provide benefits only for "full or complete" fractures or dislocations.

(13) Specified disease, also known as critical illness, dread disease, etc., insurance sold in conjunction with another insurance product, including but not limited to life insurance or annuities, shall be in the form of a separate endorsement complying with all provisions of this rule. Specified Disease insurance shall not be incorporated into a life insurance policy or annuity contract.

(14) Notice of premium change. A notice of change in premium shall be given no fewer than 45 days before the renewal date.

R590-126-6. Required Provisions.

(1) Applications.

(a) Questions used to elicit health condition information may not be vague and must reference a reasonable time frame in relation to the health condition.

(b) Completed applications shall be attached and made part of the policy.

(c) All applications shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:

"The (policy) (certificate) provides limited benefits. Review your (policy) (certificate) carefully."

(d) Application forms shall disclose the pre-existing waiting period and the requirements to receive any applicable credit for previous coverage.

(e) An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and health insurance presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used.

(f) All applications for dental and vision plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:

"The (policy) (certificate) provides (dental) (vision) benefits only. Review your (policy) (certificate) carefully."

(2) Renewal and nonrenewal provisions. Accident and health insurance shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(3) Endorsement acceptance.

(a) Except for endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder.

(b) After the date of policy issue, any endorsement that increases benefits or coverage with a concurrent increase in premium during the policy term, must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law.

(4) Additional premium. Where a separate additional premium is charged for benefits provided in connection with endorsements, the premium charge shall be set forth in the policy or certificate.

(5) Benefit payment standard. A policy or certificate that provides for the payment of benefits based on standards described as usual and customary, reasonable and customary, or words of similar import shall include a definition of the terms and an explanation of the terms in its accompanying outline of coverage.

(6) Preexisting conditions. If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations."

(7)(a) An accident only policy or certificate shall contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, as follows:

Notice to Buyer: This is an accident only (policy)(certificate) and it does not pay benefits for loss from sickness. Review your (policy)(certificate) carefully.

(b) Accident only policies or certificates that provide coverage for hospital or medical care shall contain the following statement in addition to the notice above:

This (policy)(certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

(8) Age limitation. If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy or certificate as originally issued, that fact shall be prominently set forth in the outline of coverage and schedule page.

(9) An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.

(10) Conversion privilege. If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall read "Conversion Privilege" or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

(11) Specified Disease Insurance Buyers Guide. An insurer, except a direct response insurer, shall give a person applying for specified disease insurance, a buyer's guide filed with the commissioner at the time of enrollment and shall obtain recipient's written acknowledgement of the guide's delivery. A direct response insurer shall provide the buyer's guide upon request, but not later than the time that the policy or certificate is delivered.

(12) Specified disease policies or certificates shall contain on the first page or attached to it in either contrasting color or in boldface type, at least equal to the size type used for headings or captions of sections in the policy or certificate, a prominent statement as follows:

Notice to Buyer: This is a specified disease (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all

medical expenses. Read your (policy) (certificate) carefully with the outline of coverage and the buyer's guide.

(13) Hospital confinement indemnity and limited benefit health policies or certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following:

Notice to Buyer: This is a (hospital confinement indemnity) (limited benefit health) (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

(14) Basic hospital, basic medical-surgical, and basic hospital-medical surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following:

Notice to Buyer: This is a (basic hospital) (basic medical-surgical) (basic hospital/medical-surgical) expense (policy)(certificate). This (policy) (certificate) provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage.

(15) Dental and vision coverage policies and certificates shall display prominently by type or stamp on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following:

Notice to Buyer: This (policy) (certificate) provides (dental) (vision) coverage only.

R590-126-7. Accident and Health Standards for Benefits.

The following standards for benefits are prescribed for the categories of coverage noted in the following subsections. An accident and health insurance policy or certificate subject to this rule shall not be delivered or issued for delivery unless it meets the required standards for the specified categories. This section shall not preclude the issuance of any policy or contract combining two or more categories set forth in Subsection 31A-22-605(5).

Benefits for coverages listed in this section shall include coverage of inborn metabolic errors as required by Section 31A-22-623 and Rule R590-194, and benefits for diabetes as required by Section 31A-22-626 and Rule R590-200, if applicable.

(1) Basic Hospital Expense Coverage.

Basic hospital expense coverage is a policy of accident and health insurance that provides coverage for a period of not less than 31 days during a continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness, and shall include at least the following:

(a) daily hospital room and board in an amount not less than:

(i) 80% of the charges for semiprivate room accommodations;

or

(ii) \$100 per day;

(b) miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies that are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either:

(i) 80% of the charges incurred up to at least \$3000; or

(ii) ten times the daily hospital room and board benefits; and
(c) hospital outpatient services consisting of:
(i) hospital services on the day surgery is performed;
(ii) hospital services rendered within 72 hours after injury, in an amount not less than \$250 per accident; and
(iii) x-ray and laboratory tests to the extent that benefits for the services would have been provided if rendered to an in-patient of the hospital to an extent not less than \$200;
(d) benefits provided under Subsections (a) and (b) may be provided subject to a combined deductible amount not in excess of \$200.

(2) Basic Medical-Surgical Expense Coverage.

Basic medical-surgical expense coverage is a policy of accident and health insurance that provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for and shall include at least the following:

(a) surgical services:
(i) in amounts not less than those provided on a current procedure terminology based relative value fee schedule, up to at least \$1000 for one procedure; or
(ii) 80% of the reasonable charges.
(b) anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician, or the physician assistant, performing the surgical services:
(i) in an amount not less than 80% of the reasonable charges; or
(ii) 15% of the surgical service benefit; and
(c) in-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than:

(i) 80% of the reasonable charges; or
(ii) \$100 per day.

(3) Basic Hospital/Medical-Surgical Expense Coverage.

Basic hospital/medical-surgical expense coverage is a policy of accident and health which combines coverage and must meet the requirements of both Subsections R590-126-7(1) and (2).

(4) Hospital Confinement Indemnity Coverage.

(a) Hospital confinement indemnity coverage is a policy of accident and health insurance that provides daily benefits for hospital confinement on an indemnity basis.
(b) Coverage includes an indemnity amount of not less than \$50 per day and not less than 31 days during each period of confinement for each person insured under the policy.
(c) Benefits shall be paid regardless of other coverage.

(5) Income Replacement Coverage.

Income replacement coverage is a policy of accident and health insurance that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of both that:

(a) contains an elimination period no greater than:
(i) 90-days in the case of a coverage providing a benefit of one year or less;
(ii) 180 days in the case of coverage providing a benefit of more than one year but not greater than two years; or
(iii) 365 days in all other cases during the continuance of disability resulting from sickness or injury;

(b) has a maximum period of time for which it is payable during disability of at least six months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be one month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period;

(c) where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required;

(d) a policy which provides for residual disability benefits may require a qualification period, during which the insured shall be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability;

(e) the provisions of this subsection do not apply to policies providing business buyout coverage.

(6) Accident Only Coverage.

Accident only coverage is a policy of accident and health insurance that provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least \$1,000 and a single dismemberment amount shall be at least \$500.

(7) Specified Accident Coverage.

Specified accident coverage is a policy of accident and health insurance that provides coverage for a specifically identified kind of accident, or accidents, for each person insured under the policy for accidental death or accidental death and dismemberment, combined with a benefit amount not less than \$1,000 for accidental death, \$1,000 for double dismemberment and \$500 for single dismemberment.

(8) Specified Disease Coverage.

Specified disease coverage is a policy of accident and health insurance that provides coverage for the diagnosis and treatment of a specifically named disease or diseases, and includes critical illness coverages. Any such policy shall meet these general provisions. The policy shall also meet the standards set forth in the applicable Subsections R590-126-7(8)(b), (c) or (d).

(a) General Provisions.

(i) Policy designation. Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this Subsection (8).

(ii) Medical diagnosis. Any policy issued pursuant to this section which conditions payment upon pathological diagnosis of a covered disease, shall also provide that if a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead.

(iii) Related conditions. Notwithstanding any other provision of this rule, specified disease policies shall provide benefits to any covered person, not only for the specified disease, but also for any other condition or disease directly caused or aggravated by the specified disease or the treatment of the specified disease.

(iv) Renewability. Specified disease coverage shall be at least guaranteed renewable.

(v) Probationary period. No policy issued pursuant to this section may contain a probationary period greater than 30 days.

(vi) Medicaid disclaimer. Any application for specified disease coverage shall contain a statement above the signature of the applicant that no person to be covered for specified disease is also covered by any Title XIX program, designated as Medicaid or any

similar name. Such statement may be combined with any other statement for which the insurer may require the applicant's signature.

(vii) Medical Care. Payments may be conditioned upon an insured person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.

(viii) Other insurance. Benefits for specified disease coverage shall be paid regardless of other coverage.

(ix) Retroactive application of coverage. After the effective date of the coverage, or the conclusion of an applicable probationary period, if any, benefits shall begin with the first day of care or confinement, if such care or confinement is for a covered disease, even though the diagnosis is made at some later date.

(x) Hospice. Hospice care is an optional benefit, but if offered it shall meet the following minimum standards:

(i) eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six months or less;

(ii) fixed-sum payment of at least \$50 per day; and

(iii) lifetime maximum benefit of at least \$10,000.

(b) Expense Incurred Benefits. The following benefit standards apply to specified disease coverage on an expense-incurred basis.

(i) Policy limits. A deductible amount not to exceed \$250, an aggregate benefit limit of not less than \$25,000 and a benefit period of not fewer than three years.

(ii) Copayment. Covered services provided on an outpatient basis may be subject to a copayment which may not exceed 20%.

(iii) Covered Services. Covered services shall include the following:

(A) hospital room and board and any other hospital-furnished medical services or supplies;

(B) treatment by, or under the direction of, a legally qualified physician or surgeon;

(C) private duty nursing services of a registered nurse, or licensed practical nurse;

(D) x-ray, radium, chemotherapy and other therapy procedures used in diagnosis and treatment;

(E) blood transfusions, and the administration thereof, including expense incurred for blood donors;

(F) drugs and medicines prescribed by a physician;

(G) professional ambulance for local service to or from a local hospital;

(H) the rental of any respiratory or other mechanical apparatuses;

(I) braces, crutches and wheelchairs as are deemed necessary by the attending physician for the treatment of the disease;

(J) emergency transportation if, in the opinion of the attending physician, it is necessary to transport the insured to another locality for treatment of the disease;

(K) home health care with a written prescribed plan of care;

(L) physical, speech, hearing and occupational therapy;

(M) special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and ileostomy appliances;

(N) prosthetic devices including wigs and artificial breasts;

(O) nursing home care for non-custodial services; and

(P) reconstructive surgery when deemed necessary by the attending physician.

(c) Per Diem Benefits. The following benefit standards apply to specified disease coverage on a per diem basis.

(i) Covered services shall include the following:

(A) hospital confinement benefit with a fixed-sum payment of at least \$200 for each day of hospital confinement for at least 365 days, with no deductible amount permitted;

(B) outpatient benefit with a fixed-sum payment equal to one-half the hospital inpatient benefits for each day of hospital or non-hospital outpatient surgery, radiation therapy and chemotherapy, for at least 365 days of treatment; and

(C) blood and plasma benefit with a fixed-sum benefit of at least \$50 per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.

(ii) Benefits tied to confinement in a skilled nursing home or home health care are optional. If a policy offers these benefits, they must equal the following:

(A) fixed-sum payment equal to one-half the hospital inpatient benefit for each day of skilled nursing home confinement for at least 180 days; and

(B) fixed-sum payment equal to one-fourth the hospital inpatient benefit for each day of home health care for at least 180 days.

(C) Any restriction or limitation applied to the benefits may not be more restrictive than those under Medicare.

(d) Lump Sum Benefits. The following benefit standards apply to specified disease coverage on a lump sum basis.

(i) Benefits shall be payable as a fixed, one-time payment, made within 30 days of submission to the insurer, of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of \$1,000.

(ii) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, e.g., "cancer insurance," "heart disease insurance," the same dollar amounts shall be payable regardless of the particular subtype of the disease, e.g., lung or bone cancer, with one exception. In the case of clearly identifiable subtypes with significantly lower treatment costs, e.g., skin cancer, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits.

(9) Limited Benefit Health Coverage.

Limited benefit health coverage is a policy of accident and health insurance, other than a policy covering only a specified disease or diseases, that provides benefits that are less than the standards for benefits required under this Section. These policies or contracts may be delivered or issued for delivery with the outline of coverage required by Section R590-126-8.

R590-126-8. Outline of Coverage Requirements.

(1) Basic Hospital Expense Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(1). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE I

(COMPANY NAME)

BASIC HOSPITAL EXPENSE COVERAGE

THIS (POLICY) (CERTIFICATE) PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully-This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!

Basic hospital expense coverage is designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services and hospital outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.

A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order: daily hospital room and board; miscellaneous hospital services; hospital out-patient services; and other benefits, if any.

A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits.

A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(2) Basic Medical-Surgical Expense Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(2). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE II(COMPANY NAME)BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully-This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!

Basic medical-surgical expense coverage is designed to provide, to persons insured, coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical-surgical expenses.

A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

surgical services;

anesthesia services;

in-hospital medical services; and

other benefits, if any.

A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.

A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(3) Basic Hospital/Medical-Surgical Expense Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsections R590-126-7(3). The items included in the outline of coverage must appear in the sequence prescribed.

TABLE III(COMPANY NAME)BASIC HOSPITAL/MEDICAL-SURGICAL EXPENSE COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully-This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR(POLICY) (CERTIFICATE) CAREFULLY!

Basic hospital/medical-surgical expense coverage is designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical surgical expenses.

A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

daily hospital room and board;

miscellaneous hospital services;

hospital outpatient services;

surgical services;

anesthesia services;

in-hospital medical services; and

other benefits, if any.

A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.

A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(4) Hospital Confinement Indemnity Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(4). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE IV(COMPANY NAME)HOSPITAL CONFINEMENT INDEMNITY COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully-This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and

only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Hospital confinement indemnity coverage is designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.
A brief specific description of the benefits in the following order:
daily benefit payable during hospital confinement; and duration of benefit.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefit.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.
Any benefits provided in addition to the daily hospital benefit.

(5) Income Replacement Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(5). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE V

(COMPANY NAME)

INCOME REPLACEMENT COVERAGE

THIS (POLICY) (CERTIFICATE) PROVIDES LIMITED BENEFITS BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully-This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!
Income replacement coverage is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
A brief specific description of the benefits contained in the policy.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(6) Accident Only Coverage.

An outline of coverage in the form prescribed below shall be issued in connection with policies meeting the standards of Subsection R590-126-7(6). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE VI

(COMPANY NAME)

ACCIDENT ONLY COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy) (Certificate) Carefully-This outline of coverage provides a very brief description of the important features of the coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!
Accident only coverage is designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
A brief specific description of the benefits.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(7) Specified Accident Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of R590-126-7(7). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE VII

(COMPANY NAME)

SPECIFIED ACCIDENT COVERAGE

THIS (POLICY) (CERTIFICATE) PROVIDES LIMITED BENEFITS BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully-This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Specified accident coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified accidents. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
A brief specific description of the benefits, including dollar amounts.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(8) Specified Disease Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Subsection R590-126-7(8). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE VIII

(COMPANY NAME)

SPECIFIED DISEASE COVERAGE

THIS (POLICY) (CERTIFICATE) PROVIDES LIMITED BENEFITS BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

Specified disease coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it. Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage. Read Your (Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Specified disease coverages designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses. A brief specific description of the benefits, including dollar amounts.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(9) Limited Benefit Health Coverage.

Except for dental or vision plans, an outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates which do not meet the standards of Subsections R590-126-7(1) through (8). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE IX

(COMPANY NAME)

LIMITED BENEFIT HEALTH COVERAGE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Limited benefit health coverage is designed to provide, to persons insured, limited or supplemental coverage.

A brief specific description of the benefits, including amounts.
A description of any provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(10) Dental Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with dental plan policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

TABLE X

(COMPANY NAME)

DENTAL COVERAGE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL DENTAL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
A brief specific description of the benefits.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(11) Vision Coverage.

An outline of coverage in the form prescribed below shall be issued in connection with vision plan policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

TABLE XI

(COMPANY NAME)

VISION COVERAGE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL VISION EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
A brief specific description of the benefits.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(12) An insurer shall deliver an outline of coverage to an applicant or enrollee upon the sale of an individual accident and health insurance policy as required in this rule.

(13) If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than 12 point type, immediately above the company name:

NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued.

(14) Outlines of coverage for hospital confinement indemnity, specified disease, or limited benefit policies, which are to be delivered to persons eligible for Medicare by reason of age shall contain the following language, which shall be printed on or attached to the first page of the outline of coverage:

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.

(15) Where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the commissioner for prior approval.

(16) Advertisements may fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage in this rule.

R590-126-9. Replacement of Accident and Health Insurance Requirements.

(1) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its producer, shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in Subsection (2). The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant, upon issuance of the policy, the notice described in Subsection (3). In no event, however, will the notices be required in the solicitation of the following types of policies: accident-only and single-premium nonrenewable policies.

(2) The notice required by Subsection (1) for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

TABLE XII

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by (insert company name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy. Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy. You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all

the relevant factors involved in replacing your present coverage. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded. The above "Notice to Applicant" was delivered to me on: _____ (Date) _____ (Applicant's Signature)

(3) The notice required by Subsection (1) for a direct response insurer shall be as follows:

TABLE XII

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with the policy delivered herewith issued by (insert company name) Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy. Health conditions that you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy. You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage. (To be included only if the application is attached to the policy). If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (insert company name and address) within ten days if any information is not correct and complete, or if any past medical history has been left out of the application. COMPANY NAME

R590-126-10. Existing Contracts.

Contracts issued prior to the effective date of this rule must be amended to comply with the revised provisions.

R590-126-11. Enforcement Date.

The commissioner will begin enforcing the revised provision of this rule January 1, 2006.

R590-126-12. Severability.

If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of the provision to other persons or circumstances shall not be affected thereby.

KEY: health insurance**2005****31A-2-201****31A-2-202****31A-21-201****31A-22-605****31A-22-623****31A-22-626****31A-23a-402****31A-26-301**

▼ ————— ▼

Insurance, Administration
R590-233
Health Benefit Plan Insurance
Standards

NOTICE OF PROPOSED RULE

(New Rule)

DAR FILE No.: 28047

FILED: 06/28/2005, 12:40

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this rule is to provide reasonable standardization and simplification of terms and coverages of insurance policies in order to facilitate public understanding and comparison and to prohibit provisions which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of such insurance.

SUMMARY OF THE RULE OR CHANGE: At insurers' request, the department has created this new rule from major medical provisions previously included in Rule R590-126 "Individual and Franchise Disability Insurance, Minimum Standards". (DAR NOTE: The proposed repeal and reenact of Rule R590-126 is under DAR No. 28044 in this issue.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 31A-2-201, 31A-2-202, 31A-22-605, 31A-22-623, 31A-22-626, 31A-23a-402, 31A-23a-412, and 31A-26-301

ANTICIPATED COST OR SAVINGS TO:

- ❖ **THE STATE BUDGET:** This rule will increase the department's workload due to the need to review policy forms that insurers will be required to refile with the department. Approximately 25 health insurers may be affected by the changes in the rule and will need to change and file policy forms, however, no filing fee is required.
- ❖ **LOCAL GOVERNMENTS:** This rule will have no effect on local government since the rule only applies to the relationship between health insurers, consumers, and the department.
- ❖ **OTHER PERSONS:** Approximately 25 health insurers may be affected by this rule and will need to change and file policy forms, however, no filing fee is required and no other fiscal impact should be experienced.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Approximately 25 health insurers may be affected by this rule and will need to change and file policy forms, however, no filing fee is required and no other fiscal impact should be experienced. Insurance consumers will not be financially impacted by this rule.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Health insurers already provide these benefits. There should be no fiscal impact. D. Kent Michie, Commissioner

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

INSURANCE
 ADMINISTRATION
 Room 3110 STATE OFFICE BLDG
 450 N MAIN ST
 SALT LAKE CITY UT 84114-1201, or
 at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Jilene Whitby at the above address, by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at jwhitby@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005

INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE: 8/08/2005 at 10:30 AM, State Office Building (behind the Capitol), Room 3112, Salt Lake City, UT.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: Jilene Whitby, Information Specialist

R590. Insurance, Administration.**R590-233. Health Benefit Plan Insurance Standards.****R590-233-1. Authority.**

This rule is issued by the insurance commissioner pursuant to the following provisions of the Utah Insurance Code:

(1) Subsection 31A-2-201(3)(a) authorizes rules to implement the Insurance Code;

(2) Sections 31A-2-202 and 31A-23a-412 authorize the commissioner to request reports, conduct examinations, and inspect records of any licensee;

(3) Subsection 31A-22-605(4) requires the commissioner to adopt rules to establish standards for disclosure in the sale of, and benefits to be provided by individual and franchise accident and health policies;

(4) Section 31A-22-623 authorizes the commissioner to establish by rule minimum standards of coverage for dietary products of inborn metabolic errors;

(5) Section 31A-22-626 authorizes the commissioner to establish by rule minimum standards of coverage for diabetes accident and health insurance;

(6) Subsection 31A-23a-402(8) authorizes the commissioner to define by rule acts and practices that are unfair and unreasonable; and

(7) Subsection 31A-26-301(1) authorizes the commissioner to set standards for timely payment of claims.

R590-233-2. Purpose and Scope.

(1) Purpose. The purpose of this rule is to provide reasonable standardization and simplification of terms and coverages of insurance policies in order to facilitate public understanding and comparison and to prohibit provisions which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of such insurance.

(2) Scope.

(a) Except as excluded under (b), this regulation applies to all individual and group health benefit plan policies, including policies issued to associations, trusts, discretionary groups, or other similar groupings.

(b) This rule shall not apply to employer health benefit plans.

(3) The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted.

R590-233-3. Definitions.

In addition to the definitions of Sections 31A-1-301 and 31A-22-605(2), the following definitions shall apply for the purpose of this rule.

(1) "Accident," "accidental injury," and "accidental means" shall be defined to employ result language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(a) The definition shall not be more restrictive than the following: "injury" or "injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause and that occurs while the insurance is in force.

(b) Unless otherwise prohibited by law, the definition may exclude injuries for which benefits are paid under worker's compensation, any employer's liability or similar law, or a motor vehicle no-fault plan.

(2) "Certificate of Completion" shall mean a document issued by the Utah Board of Education to a person who completes an approved course of study not leading to a diploma, or to one who passes a challenge for that same course of study, or to one whose out-of-state credentials and certificate are acceptable to the Board.

(3) "Complications of Pregnancy" shall mean diseases or conditions the diagnoses of which are distinct from pregnancy but are adversely affected or caused by pregnancy and not associated with a normal pregnancy.

(a) "Complications of Pregnancy" include acute nephritis, nephrosis, cardiac decompensation, ectopic pregnancy which is terminated, a spontaneous termination of pregnancy when a viable birth is not possible, puerperal infection, eclampsia, pre-eclampsia and toxemia.

(b) This definition does not include false labor, occasional spotting, doctor prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy.

(4) "Convalescent Nursing Home," "extended care facility," or "skilled nursing facility" shall mean a facility duly licensed and operating within the scope of such license.

(5) "Cosmetic Surgery" or "Reconstructive Surgery" shall mean any surgical procedure performed primarily to improve physical appearance.

(a) This definition does not include surgery, which is necessary:

(i) to correct damage caused by injury or sickness;

(ii) for reconstructive treatment following medically necessary surgery;

(iii) to provide or restore normal bodily function; or

(iv) to correct a congenital disorder that has resulted in a functional defect.

(b) This provision does not require coverage for preexisting conditions otherwise excluded.

(6) "Elimination Period" or "Waiting Period" means the length of time an insured shall wait before benefits are paid under the policy.

(7) "Enrollment Form" shall mean application as defined in Section 31A-1-301.

(8) "Experimental Treatment" is defined as medical treatment, services, supplies, medications, drugs, or other methods of therapy or medical practices which are not accepted as a valid course of treatment by the Utah Medical Association, the U.S. Food and Drug Administration, the American Medical Association, or the Surgeon General.

(9) "Home Health Agency" shall mean a public agency or private organization, or subdivision of a health care facility, licensed and operating within the scope of such license.

(10) "Home Health Aide" shall mean a person who obtains a Certificate of Completion, as required by law, which allows performance of health care and other related services under the supervision of a registered nurse from the home health agency, or performance of simple procedures as an extension of physical, speech, or occupational therapy under the supervision of licensed therapists.

(11) "Home Health Care" shall mean services provided by a home health agency.

(12) "Homemaker/Home Health Aide" shall mean a person who has obtained a Certificate of Completion, as required by law, which allows performance of both homemaker and home health aide services, and who provides health care and other related services under the supervision of a registered nurse from the home health agency or under the supervision of licensed therapists.

(13) "Hospice" shall mean a program of care for the terminally ill and their families which occurs in a home or in a health care facility and which provides medical, palliative, psychological, spiritual, or supportive care and treatment and is licensed and operating within the scope of such license.

(14) "Hospital" means a facility that is licensed and operating within the scope of such license. This definition may not preclude the requirement of medical necessity of hospital confinement or other treatment.

(15) "Intermediate Nursing Care" shall mean nursing services provided by, or under the supervision of, a registered nurse. Such care shall be for the purpose of treating the condition for which confinement is required.

(16) "Medical Necessity" means:

(a) health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

(i) in accordance with generally accepted standards of medical practice in the United States;

(ii) clinically appropriate in terms of type, frequency, extent, site, and duration;

(iii) not primarily for the convenience of the patient, physician, or other health care provider; and

(iv) covered under the contract;

(b) when a medical question-of-fact exists medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.

(i) For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence.

(ii) For established interventions, the effectiveness shall be based on:

(A) scientific evidence;

(B) professional standards; and

(C) expert opinion.

(17) "Medicare" means the "Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended."

(18) "Medicare Supplement Policy" shall mean an individual, franchise, or group policy of accident and health insurance, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act, 42 U.S.C. Section 1395 et seq., or an issued policy under a demonstration project specified in 41 U.S.C. Section 1395ss(g)(1), that is advertised, marketed, or primarily designed as a supplement to reimbursements under Medicare for hospital, medical, or surgical expenses of persons eligible for Medicare.

(19) "Mental or Nervous Disorders" may not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or any other mental or emotional disease or disorder which does not have a demonstrable organic cause.

(20) "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as registered nurse, or licensed practical nurse. If the words "nurse" or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with applicable statutes or administrative rules.

(21) "Nurse, Licensed Practical" shall mean a person who is registered and licensed to practice as a practical nurse.

(22) "Nurse, Registered" shall mean any person who is registered and licensed to practice as a registered nurse.

(23) "Nursing Care" shall mean assistance provided for the health care needs of sick or disabled individuals, by or under the direction of licensed nursing personnel.

(24) "Physician" may be defined by including words such as qualified physician or licensed physician. The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(25) "Probationary Period" shall mean the period of time following the date of issuance or effective date of the policy before coverage begins for all or certain conditions.

(26)(a) "Scientific evidence" means:

(i) scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or

(ii) findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.

(b) Scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

(27) "Sickness" means illness, disease, or disorder of an insured person.

(28) "Skilled Nursing Care" shall mean nursing services provided by, or under the supervision of, a registered nurse. Such care shall be for the purpose of treating the condition for which the confinement is required and not for the purpose of providing intermediate or custodial care.

(29) "Therapist" may be defined as a professionally trained or duly licensed or registered person, such as a physical therapist, occupational therapist, or speech therapist, who is skilled in applying treatment techniques and procedures under the general direction of a physician.

(30)(a) "Total Disability" shall mean an individual who:

(i) is not engaged in employment or occupation for which he is or becomes qualified by reason of education, training or experience; and

(ii) is unable to perform all of the substantial and material duties of his or her regular occupation or words of similar import.

(b) An insurer may require care by a physician other than the insured or a member of the insured's immediate family.

(c) The definition may not exclude benefits based on the individual's:

(i) ability to engage in any employment or occupation for wage or profit;

(ii) inability to perform any occupation whatsoever, any occupational duty, or any and every duty of his occupation; or

(iii) inability to engage in any training or rehabilitation program.

(31)(a) "Usual and Customary" shall mean the most common charge for similar services, medicines or supplies within the area in which the charge is incurred.

(b) In determining whether a charge is usual and customary, insurers shall consider one or more of the following factors:

(i) the level of skill, extent of training, and experience required to perform the procedure or service;

(ii) the length of time required to perform the procedure or services as compared to the length of time required to perform other similar services;

(iii) the severity or nature of the illness or injury being treated;

(iv) the amount charged for the same or comparable services, medicines or supplies in the locality; the amount charged for the same or comparable services, medicines or supplies in other parts of the country;

(v) the cost to the provider of providing the service, medicine or supply; and

(vi) other factors determined by the insurer to be appropriate.

(32) "Waiting Period" shall mean "Elimination Period."

R590-233-4. Prohibited Policy Provisions.(1) Probationary periods.

(a) A policy shall not contain provisions establishing a probationary period during which no coverage is provided under the policy, subject to the further exception that a policy may specify a probationary period not to exceed six months for specified diseases or conditions and losses resulting from disease or condition related to:

- (i) adenoids;
- (ii) appendix;
- (iii) disorder of reproductive organs;
- (iv) hernia;
- (v) tonsils; and
- (vi) varicose veins.

(b) The six-month period in Subsection (1)(a) may not be applicable where such specified diseases or conditions are treated on an emergency basis.

(2) Preexisting conditions provisions shall comply with Sections 31A-1-301, and 31A-22-605.1.

(3) Limitations or exclusions. A policy shall not limit or exclude coverage or benefits by type of illness, accident, treatment or medical condition, except as follows:

- (a) abortion;
- (b) acupuncture and acupressure services;
- (c) administrative charges for completing insurance forms, duplication services, interest, finance charges, or other administrative charges, unless otherwise required by law;
- (d) administrative exams and services;
- (e) alcoholism and drug addictions
- (f) allergy tests and treatments;
- (g) aviation;
- (h) axillary hyperhidrosis;
- (i) benefits provided under:
 - (A) Medicare or other governmental program, except Medicaid;
 - (B) state or federal worker's compensation; or
 - (C) employer's liability or occupational disease law.
- (j) cardiopulmonary fitness training, exercise equipment, and membership fees to a spa or health club;
- (k) charges for appointments scheduled and not kept;
- (l) chiropractic;
- (m) complementary and alternative medicine;
- (n) corrective lenses, and examination for the prescription or fitting thereof, but policies may not exclude required lens implants following cataract surgery;
- (o) cosmetic surgery including gastric bypass; reversal, revision, repair or treatment related to a non-covered cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;
- (p) custodial care;
- (q) dental care or treatment.
- (r) dietary products, except as required by Rule R590-194;
- (s) educational and nutritional training, except as required by Rule R590-200;
- (t) experimental and/or investigational services;
- (u) felony, riot or insurrection, when the insured is a voluntary and active participant;

(v) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, including orthotics. The exclusion of routine foot care does not apply to cutting or removal of corns, calluses, or nails when provided to a person who has a systemic disease, such as diabetes with peripheral neuropathy or circulatory insufficiency, of such severity that unskilled performance of the procedure would be hazardous;

- (w) gene therapy;
- (x) genetic testing;
- (y) hearing aids, and examination for the prescription or fitting thereof;
- (z) illegal activities, limited to losses related directly to the insured's voluntary participation;
 - (aa) infertility services, except as required by Rule R590-76;
 - (bb) interscholastic sports, with respect to short-term nonrenewable policies;
 - (cc) mental or emotional disorders;
 - (dd) motor vehicle no-fault law, except when the covered person is required by law to have no-fault coverage, the exclusion applies to charges up to the minimum coverage required by law whether or not such coverage is in effect;
 - (ee) nuclear release;
 - (ff) preexisting conditions or diseases as allowed under Section 31A-22-605.1, except for coverage of congenital anomalies as required by Section 31A-22-610;
 - (gg) pregnancy, except for complications of pregnancy;
 - (hh) refractive eye surgery;
 - (ii) rehabilitation therapy services, such as physical, speech, and occupational, unless required to correct an impairment caused by a covered accident or illness;
 - (jj) respite care;
 - (kk) rest cures;
 - (ll) routine physical examinations;
 - (mm) service in the armed forces or units' auxiliary to it;
 - (nn) services rendered by employees of hospitals, laboratories or other institutions;
 - (oo) services performed by a member of the covered person's immediate family;
 - (pp) services for which no charge is normally made in the absence of insurance;
 - (qq) sexual dysfunction;
 - (rr) shipping and handling, unless otherwise required by law;
 - (ss) suicide, sane or insane, attempted suicide, or intentionally self-inflicted injury;
 - (tt) telephone/electronic consultations;
 - (uu) territorial limitations outside the United States;
 - (vv) terrorism, including acts of terrorism;
 - (ww) transplants;
 - (xx) transportation;
 - (yy) treatment provided in a government hospital, except for hospital indemnity policies; or
 - (zz) war or act of war, whether declared or undeclared.
- (4) Waivers. All waivers issued must comply with 31A-30-107.5. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required.
- (5) Commissioner authority. Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to prohibit other policy provisions that in the opinion of the commissioner are unjust, unfair or unfairly

discriminatory to the policyholder, beneficiary or a person insured under the policy.

R590-233-5. General Requirements.

(1) Policy definitions. No policy subject to this rule may contain definitions respecting the matters defined in Section R590-233-3 unless such definitions comply with the requirements of that section.

(2) Rights of spouse. The following provisions apply to policies that provide coverage to a spouse of the insured:

(a) A policy may not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than for nonpayment of premium.

(b) A policy shall provide that in the event of the insured's death the spouse of the insured shall become the insured.

(3) Cancellation, Renewability, and Termination. Policy cancellation, renewability and termination provisions must comply with Sections 31A-8-402.3, 31A-8-402.5, 31A-8-402.7 31A-22-721 and 31A-30-107, 107.1 and 107.3.

(4) Termination of the policy shall be without prejudice to a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.

(5) Military service. If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.

(6) Pregnancy benefit extension. In the event the insurer cancels or refuses to renew a policy providing pregnancy benefits, the policy shall provide an extension of benefits for a pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force. This requirement does not apply to a policy that is canceled for the following reasons:

(a) the insured fails to pay the required premiums in accordance with the terms of the plan; or

(b) the insured person performs an act or practice that constitutes fraud in connection with the coverage or makes an intentional misrepresentation of material fact under the terms of the coverage.

(7) Transplant donor coverage. A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.

(8) Notice of premium change. A notice of change in premium shall be given no fewer than 45 days before the renewal date.

R590-233-6. Required Provisions.

(1) Applications.

(a) Questions used to elicit health condition information may not be vague and must reference a reasonable time frame in relation to the health condition.

(b) Completed applications shall be attached and made part of the policy.

(d) Application forms shall disclose the pre-existing waiting period and the requirements to receive any applicable credit for previous coverage.

(e) An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and health insurance presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used.

(2) Renewal and nonrenewal provisions. Accident and health insurance shall include a renewal, continuation or nonrenewal provision. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(3) Endorsement acceptance.

(a) Except for endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder.

(b) After the date of policy issue, any endorsement that increases benefits or coverage with a concurrent increase in premium during the policy term, must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law.

(4) Additional premium. Where a separate additional premium is charged for benefits provided in connection with endorsements, the premium charge shall be set forth in the policy or certificate.

(5) Benefit payment standard. A policy or certificate that provides for the payment of benefits based on standards described as usual and customary, reasonable and customary, or words of similar import shall include a definition of the terms and an explanation of the terms in its accompanying outline of coverage.

(6) Preexisting conditions. If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations."

(7) Conversion privilege. If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall read "Conversion Privilege" or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

R590-233-7. Accident and Health Standards for Benefits.

The following standards for benefits are prescribed for the categories of coverage noted in the following subsections. An accident and health insurance policy or certificate subject to this rule shall not be delivered or issued for delivery unless it meets the required standards for the specified categories. This section shall not preclude the issuance of any policy or contract combining two or more categories set forth in Subsection 31A-22-605(5).

Benefits for coverages listed in this section shall include coverage of inborn metabolic errors as required by Sections 31A-22-623 and Rule R590-194, and benefits for diabetes as required by Sections 31A-22-626 and Rule R590-200, if applicable.

(1) Major Medical Expense Coverage.

Major medical expense coverage is a policy of accident and health insurance that provides hospital, medical and surgical expense coverage.

(a) An aggregate maximum of not less than \$1,000,000 may be applied and include any combination of the following:

(i) coinsurance percentage, paid by the covered person, not to exceed 50% of covered charges per covered person per year;

(ii) coinsurance out-of-pocket maximum after any deductibles not to exceed \$20,000 per covered person per year; or

(iii) deductibles stated on per person, per family, per illness, per benefit period, or per year basis.

(b) A combination of the bases provided under Subsections(1)(a)(i), (ii), and (iii) may not exceed 5% of the aggregate maximum limit under the policy for each covered person.

(c) The following services must be provided:

(i) daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;

(ii) miscellaneous hospital services;

(iii) surgical services;

(iv) anesthesia services;

(v) in-hospital medical services;

(vi) out-of-hospital care, consisting of physician services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

(vii) at least three of the following additional benefits must also be provided:

(A) in-hospital private duty registered nurse services;

(B) convalescent nursing home care;

(C) diagnosis and treatment by a radiologist or physiotherapist;

(D) rental of special medical equipment, as defined by the insurer in the policy;

(E) artificial limbs or eyes, casts, splints, trusses or braces;

(F) treatment for functional nervous disorders, and mental and emotional disorders; or

(G) out-of-hospital prescription drugs and medications.

(d) All required benefits may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations.

(e) A major medical expense policy may also have special or internal limitations for those services covered under Subsection (1)(c).

(f) Except as authorized by this subsection through the application of special or internal limitations, a major medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.

(2) Basic Medical Expense Coverage.

Basic medical expense coverage is a policy of accident and health insurance that provides hospital, medical and surgical expense coverage.

(a) An aggregate maximum of not less than \$500,000 may be applied, and may include any combination of the following:

(i) coinsurance percentage, paid by the covered person, not to exceed 50% of covered charges per covered person per year;

(ii) coinsurance out-of-pocket maximum after any deductibles, not to exceed \$25,000 per covered person per year; or

(iii) deductibles stated on per person, per family, per illness, per benefit period, or per year basis.

(b) A combination of the bases provided in Subsections (2)(a)(i), (ii) and (iii) may not exceed 10% of the aggregate maximum limit under the policy.

(c) The following services must be covered:

(i) daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides or such other rate agreed to between the insurer and provider for a period of not less than 31 days during continuous hospital confinement;

(ii) miscellaneous hospital services;

(iii) surgical services;

(iv) anesthesia services;

(v) in-hospital medical services;

(vi) out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy and hemodialysis ordered by a physician; and

(vii) three of the following additional benefits must also be provided:

(A) in-hospital private duty registered nurse services;

(B) convalescent nursing home care;

(C) diagnosis and treatment by a radiologist or physiotherapist;

(D) rental of special medical equipment, as defined by the insurer in the policy;

(E) artificial limbs or eyes, casts, splints, trusses or braces;

(F) treatment for functional nervous disorders, and mental and emotional disorders; or

(G) out-of-hospital prescription drugs and medications.

(d) If the policy is written to complement underlying basic hospital expense coverage and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying basic coverage.

(e) The benefits required by Subsection (2) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations.

(f) Basic medical expense policies may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under Subsection (2)(c) and other such special or internal limitations as are authorized or approved by the commissioner.

(g) Except as authorized by this subsection through the application of special or internal limitations, basic medical expense policies must be designed to cover, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.

(3) Catastrophic Coverage.

Catastrophic coverage is a policy of accident and health insurance that:

- (a) provides benefits for medical expenses incurred by the insured to an aggregate maximum of not less than \$1,000,000;
- (b) contains no separate internal dollar limits;
- (c) may be subject to a policy deductible which does not exceed the greater of 2% of the policy limit or the amount of other in-force accident and health insurance coverage for the same medical expenses; and
- (d) contains no percentage participation or coinsurance clause for expenses which exceed the deductible.

R590-233-8. Outline of Coverage Requirements.

(1) Major Medical Expense Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Rule R590-233-7(1). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE I

(COMPANY NAME)
MAJOR MEDICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

Read Your (Policy) (Certificate) Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY! Major medical expense coverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.
A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:
daily hospital room and board;
miscellaneous hospital services;
surgical services;
anesthesia services;
in-hospital medical services;
out-of-hospital care;
maximum dollar amount for covered charges; and
other benefits, if any.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(2) Basic Medical Expense Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-233-7(2). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE II

(COMPANY NAME)
BASIC MEDICAL EXPENSE COVERAGE
THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS
OUTLINE OF COVERAGE

Read Your (Policy) (Certificate) Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Basic medical expense coverage is designed to provide, to persons insured, limited coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.
A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:
daily hospital room and board;
miscellaneous hospital services;
surgical services;
anesthesia services;
in-hospital medical services;
out-of-hospital care;
maximum dollar amount for covered charges; and
other benefits, if any.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(3) Catastrophic Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-233-7(3). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE III

(COMPANY NAME)
CATASTROPHIC COVERAGE
OUTLINE OF COVERAGE

Read Your (Policy) (Certificate) Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Catastrophic coverage is designed to provide benefits for medical expenses incurred by the insured. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles with no separate internal dollar limits.

A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:

- daily hospital room and board;
- miscellaneous hospital services;
- surgical services;
- anesthesia services;
- in-hospital medical services;
- out-of-hospital care; and
- other benefits, if any.

A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.

A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(4) An insurer shall deliver an outline of coverage to an applicant or enrollee upon the sale of an individual accident and health insurance policy as required in this rule.

(5) If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than 12-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued."

(6) Where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the commissioner for prior approval.

(7) Advertisements may fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage in this rule.

R590-233-9. Replacement of Accident and Health Insurance Requirements.

(1) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its producer, shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in Subsection (2). The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant, upon issuance of the policy, the notice described in Subsection (3).

(2) The notice required by Subsection (1) for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

TABLE IV

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by (insert company name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy. Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy.

whereas a similar claim might have been payable under your present policy.

You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

.....

(Date)

.....

(Applicant's Signature)

(3) The notice required by Subsection (1) for a direct response insurer shall be as follows:

TABLE V

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with the policy delivered herewith issued by (insert company name) Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

Health conditions that you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy. You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(To be included only if the application is attached to the policy). If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (insert company name and address) within ten days if any information is not correct and complete, or if any past medical history has been left out of the application. COMPANY NAME

R590-233-10. Existing Contracts.

Contracts issued prior to the effective date of this rule must be amended to comply with the revised provisions.

R590-233-11. Enforcement Date.

The commissioner will begin enforcing the revised provision of this rule January 1, 2006.

R590-233-12. Severability.

If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of the provision to other persons or circumstances shall not be affected thereby.

KEY: health insurance**2005****31A-2-201****31A-2-202****31A-22-605****31A-22-623****31A-22-626****31A-23a-402****31A-23a-412****31A-26-301**

Natural Resources, Parks and
Recreation
R651-205-9
Jordan River

NOTICE OF PROPOSED RULE
(Amendment)

DAR FILE NO.: 28056
FILED: 06/30/2005, 16:08

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this rule amendment is to allow small boats with motors less than 10 horsepower (hp) to use the Utah County portion of the Jordan River. Fishermen like to use this part of the river, and it is difficult to row a small boat back upstream.

SUMMARY OF THE RULE OR CHANGE: Motors with less than 10 hp are barely audible, and cause no wake, but in the area of Utah County on the Jordan River, all motors have been prohibited. It is recommended that this be corrected to allow such motors to be used on the Utah County portion of the Jordan River. Landowners, agencies, and users were contracted before this recommended change was made.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 73-18-4(1)(c)

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: It does not appear that allowing small motors to operate on the Utah County portion of the Jordan River will not affect the state budget, or have any cost or savings at this time, since it has not been allowed previously and there are no numbers of users that will use that portion of the Jordan River. It will take a season of usage on the Utah

County portion of the Jordan River to see if there is any impact.

❖ LOCAL GOVERNMENTS: There are no anticipated costs or savings to local government due to this change in the rule since this has not been allowed in the past and it will take a season to find out if there is any negligible impact.

❖ OTHER PERSONS: There are no anticipated costs or savings to any other persons due to this change in the rule, as it is allowing them to use a portion of the Jordan River in Utah County for motors with less than 10 hp. If any of them decided to buy a motor with less than 10 horsepower, that would be the cost to them and there is no way at this time to know how many will use the Jordan River (Utah County portion).

COMPLIANCE COSTS FOR AFFECTED PERSONS: Persons owning small motors (less than 10 hp) will have the right to navigate on the Utah County portion of the Jordan River. Since it has not been allowed previously, there are no numbers to use to see how many people will be taking advantage of this amendment. The only cost that could possibly be expected would be if someone decided to buy a motor with less than 10 hp so they can navigate that portion of the Jordan River.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Impacts to businesses are likely to be small and positive, as businesses gain the opportunity of providing goods and services to a new segment of recreational users. Michael Styler, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

NATURAL RESOURCES
PARKS AND RECREATION
Room 116
1594 W NORTH TEMPLE
SALT LAKE CITY UT 84116-3154, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Dee Guess at the above address, by phone at 801-538-7320, by FAX at 801-537-3144, or by Internet E-mail at deeguess@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: Mary Tullius, Director

R651. Natural Resources, Parks and Recreation.
R651-205. Zoned Waters.
R651-205-9. Jordan River.

The use of motors is prohibited, except motors whose manufacture listed horsepower is less than 10 horsepower. Such motors are permitted on the Utah County portion of the river.

KEY: boating
~~January 15, 2005~~ August 16, 2005
 Notice of Continuation November 13, 2001
 73-18-4(1)(c)

▼ ————— ▼

**Public Service Commission,
 Administration
 R746-510
 Funding for Speech and Hearing
 Impaired Certified Interpreter Training**

NOTICE OF PROPOSED RULE

(New Rule)
 DAR FILE NO.: 28057
 FILED: 06/30/2005, 16:11

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This proposed new rule establishes uniform administrative requirements for the use of funds from the Hearing and Speech Impaired telephone surcharge pursuant to Subsection 54-8b-10(5)(b)(vi).

SUMMARY OF THE RULE OR CHANGE: This new rule provides guidelines for eligibility, proposals, funding, subcontractors, accountability, general administrative responsibilities, and record keeping for the award and use of funds from the Hearing and Speech Impaired surcharge.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 54-8b-10(5)(b)(vi)

ANTICIPATED COST OR SAVINGS TO:

❖ **THE STATE BUDGET:** There will be no costs or savings to any state agency as the rule only affects the Commission's administration of this additional activity, with which the Legislature charged the Commission in amending Section 54-8b-10. The Commission anticipates that there will be no costs or savings arising directly from the rule itself. Other costs or savings were considered by the Legislature in its deliberations and passage of the statutory amendment through H.B. 145 in the 2005 legislative general session. (DAR NOTE: H.B. 145 is found at UT L 2005 Ch 278, and was effective 05/02/2005.)

❖ **LOCAL GOVERNMENTS:** None--The rule does not affect any local government activity. The Commission does not anticipate that any local government entities will be involved in any contracts with the Commission. To the extent that they may participate, see "Other persons" below.

❖ **OTHER PERSONS:** None--There are no direct costs or savings that arise from this new rule. Organizations that wish to respond to requests for proposals issued pursuant to the State procurement program will incur expenses in preparing their proposals, but this results from their voluntary decision to pursue a contract with the State. Organizations that obtain contracts will also incur costs, again this results from their voluntary decision to contract with the State and render services. It is anticipated that these costs will be recovered

from the contract payments these contractors will receive in performance of their contracts.

COMPLIANCE COSTS FOR AFFECTED PERSONS: None arising from the rule. Costs arising from the contracts will be dependent upon the services provided and will be recovered through contract payments.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The 2005 Legislature amended Section 54-8b-10 to authorize the Commission use Hearing and Speech Impaired funds for the additional purpose of providing funds for programs which train certified interpreters.

The statutory amendment also required the Commission to promulgate rules for the administration of monies for this new purpose. The rule itself will not have a direct impact upon businesses. Utah businesses will receive an indirect benefit from the new program if it is successful in increasing the number of certified interpreters who may provide their services in the State of Utah. Ric Campbell, Chairman

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

PUBLIC SERVICE COMMISSION
 ADMINISTRATION
 HEBER M WELLS BLDG
 160 E 300 S
 SALT LAKE CITY UT 84111-2316, or
 at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Sandy Mooy or Barbara Stroud at the above address, by phone at 801-530-6708 or 801-530-6714, by FAX at 801-530-6796 or 801-530-6796, or by Internet E-mail at smooy@utah.gov or bstroud@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005

INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE: 7/28/2005 at 9:00 AM, Heber M. Wells Building, 160 E 300 S, Fourth Floor, Room 426, Salt Lake City, UT.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: Barbara Stroud, Paralegal

**R746. Public Service Commission, Administration.
 R746-510. Funding for Speech and Hearing Impaired Certified
 Interpreter Training.**

R746-510-1. Authority and Purpose.

A. Authority -- This rule is authorized by 54-8b-10(5)(c) which requires the Public Service Commission to adopt rules in accordance with its responsibilities.

B. Purpose -- The purpose of this rule is to establish uniform administrative requirements for the distribution of funds from the telephone surcharge to be awarded by contract to institutions within the state system of higher education, or to the Division of Services to

the Deaf and Hard of Hearing, for training persons to qualify as certified interpreters for deaf, hard of hearing or severely speech impaired persons, pursuant to 54-8b-10(5)(b)(vi).

R746-510-2. Definitions.

A. Definitions -- The meaning of terms used in these rules shall be consistent with the definitions provided in 54-8b-10(1), R746-343-2 or these rules. As used in these rules, the following definitions shall apply.

1. "Certified Interpreter" means a person who is certified as meeting the certification requirements of Title 53A, Chapter 26a, the Interpreter Services for the Hearing Impaired Act.

2. "Contract" means an award of a contractual agreement by the Commission to an eligible recipient.

3. "DaHH Division" means the Division of Services to the Deaf and Hard of Hearing, as created by 53A-24-402.

4. "Recipient" means the legal entity to which a contract is awarded and which is accountable for the use of the funds provided. The recipient is the entire legal entity even if a particular component of the entity is designated in the contract document. The term "recipient" shall also include all subcontractors.

5. "Subcontractor" means any corporation, partnership, individual, sole proprietorship, joint stock company, joint venture, or any other private legal entity, who has a contract with any recipient to perform any portion of the services or work required under a contract. A "subcontractor" does not include suppliers who provide property, including equipment, materials, and printing to a recipient or subcontractor.

R746-510-3. Eligibility Requirements.

A. Eligibility -- An organization is eligible if it is:

1. an institution within the state system of higher education listed in Section 53B-1-102 that offers a program approved by the Board of Regents for training persons to qualify as certified interpreters; or

2. the DaHH Division.

R746-510-4. Proposal and Funding.

A. Process -- The Commission will solicit proposals in conformity to the Utah Procurement Code, Title 63, Chapter 56, and applicable rules.

1. Eligible organizations shall submit a proposal to request funding.

2. Funds will be disbursed pursuant to the terms of contracts that may be negotiated from the proposals submitted.

3. Contracts, allocations and distributions shall be at the discretion of the Commission.

R746-510-5. Subcontractors.

A. Identification of subcontractors -- A proposal may not include subcontract work covered by this rule unless:

1. the subcontractor is specifically identified in the proposal;

2. the subcontractor complies with all applicable Board requirements;

3. the proposal provides the same information for each subcontractor in the same manner as if the subcontract work was procured directly by the Commission;

4. the proposal includes a copy of all subcontractor contracts; and

5. all subcontractors look solely to recipient for payment.

R746-510-6. Accountability.

A. On-site visits -- In addition to any request for proposal or contact requirements, organizations that seek or have a contract will permit the Commission, its representatives or its designees to visit prior to and during a contract period to evaluate the organization's effectiveness and preparedness.

B. Recipient Report Filing -- A recipient receiving funding shall file an annual report with the Commission on or before July 1 for the preceding year.

C. Report contents -- The annual report shall contain the following information:

1. a budget expenditure report and income source report; and

2. description of its program, which includes, but is not limited to, the number of students and teachers served, the graduation rate and the number of students who become certified as a certified interpreter, employment information for graduating students and those who become certified interpreters;

3. a description of services provided by the recipient pursuant to the contract, and if requested, copies of any and all materials developed; and

4. other information which may be specified in the contract.

R746-510-7. General Administrative Responsibilities.

A. Administration -- A recipient shall comply with applicable statutes, regulations, and the contract, and shall use funds in accordance with those statutes, regulations, and the contract.

B. Supervision -- A recipient shall directly supervise the administration of the contract and funds received.

C. Accounting -- A recipient shall use fiscal control and fund accounting procedures that insure proper disbursement of and accounting for funds received.

R746-510-8. Records.

A. Records -- In addition to any contract requirement,

1. A recipient shall keep records that record:

a. The amount of funds awarded and received under the contract;

b. How the recipient uses the funds;

c. The total cost of the proposal;

d. The share of the costs provided from other sources and identification of such sources;

e. The identity of students participating in a program supported by the contract; and

f. Other records to facilitate an effective audit.

2. A recipient shall keep records that demonstrate its compliance with contract and rule requirements.

3. A recipient is responsible for managing and monitoring each program supported by the contract.

B. Retention and Access Requirements for Records--

1. All financial records, supporting documents, statistical records, and all other records pertinent to a contract shall be retained for a period consistent with Government Records Access and Management Act, Title 63, Chapter 2 and any term specified in a contract.

2. The Commission or any of its duly authorized representatives or designees, have the right of timely and unrestricted access to any books, documents, papers, or other records of recipients that are pertinent to the contracts, in order to make audits, examinations, excerpts, transcripts, and copies of documents. This right also includes timely and reasonable access to

a recipient's personnel for the purpose of interview and discussion related to these documents and a contract program. The rights of access are not limited to the required retention period, but shall last as long as records are retained.

3. All procurement records shall be retained and disposed of in accordance with the Government Records Access and Management Act, Title 63, Chapter 2.

R746-510-9. Termination of Awards.

A. Termination of Contracts -- Contracts may be terminated in whole or in part:

1. By the Commission if a recipient fails to comply with the terms and conditions of a contract; or

2. With the consent of the Commission; or

3. Pursuant to the terms of a contract.

4. No provision of this rule shall preclude or prevent the Commission from terminating or modifying a contract for any reason or means not listed in this rule.

R746-510-10. Enforcement.

A. Enforcement -- If a recipient fails to comply with the terms and conditions of a contract, in addition to any remedy provided by law or contract, the Commission may take one or more of the following actions, as the Commission may deem appropriate in the circumstances:

1. Withhold payments pending correction of the deficiency by the recipient or more severe enforcement action by the Commission.

2. Deny the use of contract funds for all or part of the cost of the activity or action not in compliance.

3. Wholly or partly suspend or terminate the current contract.

4. Or any other action which the Commission may determine appropriate.

KEY: speech impaired, hearing impaired, training, interpreters 2005 54-8b-10(5)(b)(vi)



Regents (Board Of), Administration
R765-685
 Utah Educational Savings Plan Trust

NOTICE OF PROPOSED RULE

(Repeal)

DAR FILE NO.: 28062

FILED: 07/01/2005, 10:12

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule is being repealed because it conflicts with Title 53B, Chapter 8a, of the Utah Code, which was updated with the passage of H.B. 102 in the 2005 General Session. In addition, because the policies for the Utah Educational Savings Plan (UESP) are directed to account owners who have signed a contractual agreement with UESP such policies are not appropriate to be in an administrative rule. (DAR NOTE: H.B. 102 is found at UT L 2005 Ch 109, and was effective 03/16/2005.)

SUMMARY OF THE RULE OR CHANGE: This rule is repealed in its entirety.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 53B, Chapter 8a

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: The changes to this rule will have no fiscal impact on the department's or the state's budget. UESP is a trust fund containing investments of account owners. No state funds are involved. The program is operated using the fees charged to account owners that voluntarily enroll.

❖ LOCAL GOVERNMENTS: The changes to this rule will have no fiscal impact on local government. UESP is a trust fund containing investments of account owners. No local government funds are involved. The program is operated using the fees charged to account owners that voluntarily enroll.

❖ OTHER PERSONS: The changes to this rule will have no fiscal impact on other persons. UESP is a trust fund containing investments of account owners. The program is operated using the fees charged to account owners that voluntarily enroll.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The only costs would be those incurred by an interested party in accessing UESP information. There should be limited costs because the information is available in multiple ways.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The only costs would be those incurred by an interested party in accessing UESP information. There should be limited costs because the information is available in multiple ways. Richard Kendall, Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

REGENTS (BOARD OF)
 ADMINISTRATION
 BOARD OF REGENTS BUILDING, THE GATEWAY
 60 SOUTH 400 WEST
 SALT LAKE CITY UT 84101-1284, or
 at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Becky Lang at the above address, by phone at 801-366-8447, by FAX at 801-321-7299, or by Internet E-mail at blang@utahsbr.edu

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM ON 08/15/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: Richard E. Kendell, Commissioner

R765. Regents (Board of), Administration.**~~R765-685. Utah Educational Savings Plan Trust.~~****~~R765-685-1. Purpose.~~**

~~— To provide rules for the administration and operation of the Utah Educational Savings Plan Trust established by Title 53B, Chapter 8a, of the Utah Code Annotated 1953.~~

~~R765-685-2. References.~~

- ~~— 2.1. Title 53B, Chapter 8a, Utah Code Annotated 1953~~
- ~~— 2.2. Title 67, Chapter 16, Utah Code Annotated 1953~~
- ~~— 2.3. Title 51, Chapter 7, Utah Code Annotated 1953~~

~~R765-685-3. Definitions.~~

~~— Many terms used in this rule are defined in Section 53B-8a-102. In addition, the following terms are defined by this rule.~~

- ~~— 3.1. The term "academic period" shall mean one semester or one quarter or an equivalent period for a vocational technical institution.~~
- ~~— 3.2. The word "account" shall denote the account in the program fund established and maintained under the trust for a beneficiary.~~
- ~~— 3.3. The term "account balance" shall mean the fair market value of an account as of the accounting date.~~
- ~~— 3.4. The term "accounting date" shall mean the date, not later than the last business day of each quarter as determined by the program administrator.~~
- ~~— 3.5. The term "administrative fee or charge" shall mean a fee charged by the trust authorized by 53B-8a-103(k), consisting of (i) an annual account maintenance fee payable to the administrative fund, deducted from the account assets held under the participation agreements of participants (but not deducted from the account assets of participants selecting option 1), not to exceed \$50 annually; and (ii) a daily charge deducted from the assets of participants (but not charged to accounts of participants selecting option 1) in the program fund at a rate equivalent to an annual effective rate of not more than 0.50%, no more than 0.25% of which shall be payable to the administrative fund, and no more than 0.25% of which shall be payable to the investment advisor for the trust.~~
- ~~— 3.6. The term "dependent person" shall mean a person who is unable to meet all of the criteria listed in subsection 3.8 of this rule.~~
- ~~— 3.7. The term "domicile" shall mean a person's true, fixed and permanent home. It is the place where the person intends to remain, and to which the person expects to return without intending to establish a new domicile elsewhere.~~
- ~~— 3.8. The term "independent person" shall mean a person who meets all of the following criteria. An independent person is one:~~
 - ~~— 3.8.1. whose parent has not claimed such person as a dependent on federal or state income tax returns for the tax year preceding the date of a request to establish a vested participation agreement;~~
 - ~~— 3.8.2. who demonstrates no financial dependence upon parent(s); and~~
 - ~~— 3.8.3. whose parents' income is not taken into account by any private or governmental agency furnishing educational financial assistance to the person, including scholarships, loans, and other assistance.~~
- ~~— 3.9. "Investment options" shall mean the investment options available for selection by a participant at the time of enrollment or change of option. Investment risk under the options ranges from conservative to most aggressive. There are no guarantees regarding moneys invested under any option, either as to earnings or as to~~

~~return of principal. The value of each participant account depends on the performance of the investments selected by the trust. Each participant assumes the investment risks associated with the investment option selected. Once an investment option is selected, a participant may not change to another investment option unless authorized by the Internal Revenue Service or Treasury as being in compliance with Section 529 of the Internal Revenue Code.~~

- ~~— 3.10. "Notice to Delay Trust Benefits" shall mean the form which a participant submits to the program administrator of the trust to delay benefits under a participation agreement.~~
- ~~— 3.11. "Notice to Adjust Payments" shall mean the form which a participant submits to the program administrator of the trust to change the payment amount or payment schedule of the participation agreement.~~
- ~~— 3.12. "Request to Substitute Beneficiary" shall mean the form which a participant submits to the program administrator of the trust to request the substitution of a beneficiary.~~
- ~~— 3.13. "Notice to Terminate Agreement" shall mean the form which a participant submits to the program administrator of the trust to terminate a participation agreement under the trust.~~
- ~~— 3.14. "Notice to Use Trust Benefits" shall mean the form which a participant submits to the program administrator of the trust to notify the trust of the date benefits are to begin and level of benefits to be paid.~~
- ~~— 3.15. The term "parent" shall mean one of the following:~~
 - ~~— 3.15.1. A person's father or mother; or~~
 - ~~— 3.15.2. A court appointed legal guardian. The term "parent" shall not apply if the guardianship has been established primarily for the purpose of conferring the status of resident on a person.~~
- ~~— 3.16. The word "payments" shall denote the money paid by the participant to the trust under the participation agreement.~~
- ~~— 3.17. The term "public treasurer" shall mean the Assistant Commissioner for Student Loan Finance who has the responsibility for the safekeeping and investment of all trust funds.~~
- ~~— 3.18. The term "qualified proprietary school approved by the board" shall mean a proprietary school which is fully accredited by a regional accrediting association or commission, the Accrediting Commission for Career Schools and Colleges of Technology, or the Accrediting Council for Independent Colleges and Schools, for which the student loan cohort default rate most recently published by the U.S. Department of Education is less than 20 percent, and which has not been placed on a reimbursement basis for financial aid programs by the U.S. Department of Education or under any limitation, suspension, or termination action or letter of credit requirement from the U.S. Department of Education or a guaranty agency under the Federal Family Education Loan Program.~~

~~R765-685-4. Participant Eligibility.~~

~~— Purpose—Section 53B-8a-106 provides that the trust may enter into participation agreements with participants to effectuate the purposes, objectives and provisions of the trust. This rule establishes the eligibility criteria for a participant.~~

- ~~— 4.1. Participant Eligibility—A participant may be a resident of any state.~~
- ~~— 4.2. Participation Agreement—A participant shall execute a participation agreement with the program administrator that specifies the terms and conditions under which the participant shall participate in the trust.~~
- ~~— 4.3. Valid Social Security Number—A participant shall, on signing a participation agreement, provide the program administrator with his or her valid social security number.~~

R765-685-5. Beneficiary Eligibility.

— Purpose — Section 53B-8a-106 provides that a beneficiary of a participation agreement must be designated from date of birth through age 18 for the participant to receive Utah income tax benefits. This rule establishes the eligibility criteria for a beneficiary.

— 5.1. Beneficiary Eligibility — A beneficiary may be a resident of any state and may be any age. However, for a participant to subtract allowable investments from federal taxable income on a Utah income tax return, on the day the participation agreement is executed, the beneficiary must be younger than 19 years of age.

— 5.2. Proof of Age — A participant shall, on signing a participation agreement, provide the program administrator with proof of the beneficiary's age, in the form of a birth certificate or such other form as the program administrator may require.

— 5.3. Valid Social Security Number — A participant shall, on signing a participation agreement, provide the program administrator a valid social security number of the beneficiary.

R765-685-6. Payments and Payment Schedules.

— Purpose — Section 53B-8a-106 states that participant agreements shall require participants to agree to invest a specific amount of money in the trust for a specific period of time for the benefit of a specific beneficiary, not to exceed an amount determined by the board and not to exceed total estimated higher education costs as determined by the board. This rule provides for implementation of this provision.

— 6.1. Payment Schedule — A participant must specify a schedule for making payments according to a participation agreement. Acceptable payment schedules are, 1) weekly, 2) bi-weekly, 3) monthly, 4) annually, and 5) other.

— 6.2. Payment — A participant must specify a payment amount to be paid according to the payment schedule chosen by the participant. The specified payment amount must be at least twenty-five dollars.

— 6.3. Maximum Payments — The total of all payments made on behalf of a beneficiary into this trust and the supplemental trust enacted in Section 53B-8b may not exceed the cost of qualified higher education expenses for four years of undergraduate plus three years of graduate enrollment at the highest cost public or private institution authorized under the plan. Payments in excess of this maximum shall be returned to the participant. The maximum amount of investments that may be subtracted from federal taxable income under Subsection 59-10-114(2)(j) shall be \$1,200 for each individual beneficiary for the 1996 calendar year and an amount adjusted annually thereafter to reflect increases in the Consumer Price Index.

— 6.4. Annual Adjustments — Annual adjustments to the maximum amount of payments allowable under a participation agreement in a given calendar year shall be published by the Trust program administrator prior to the beginning of that year.

— 6.5. Amendments — Payment amounts and payment schedules may be adjusted by submitting to the program administrator notice to adjust payments. No administrative fee may be charged to participants for such adjustments.

R765-685-7. Substitution of Beneficiary.

— Purpose — Section 53B-8a-106 provides that beneficiaries may be changed subject to the rules and regulations of the board. This rule establishes the criteria for substituting one beneficiary for another.

— 7.1. Substitution — A participant may substitute a beneficiary at any time prior to the date of admission of any beneficiary of a participation agreement to an institution of higher education and may transfer funds to another beneficiary account at any time. The substitute beneficiary must be eligible for participation pursuant to section 5 of this rule, and be a member of the family of the beneficiary being substituted as defined in subsection 7.1.1 of this rule.

— 7.1.1. Member of Family — An individual shall be considered a member of a beneficiary's family only if such individual is:

— 7.1.1.1. an ancestor of such beneficiary

— 7.1.1.2. a spouse of such beneficiary

— 7.1.1.3. a lineal descendant of such beneficiary, of such beneficiary's spouse, or of a parent or grandparent of such beneficiary, or

— 7.1.1.4. the spouse of any lineal descendant described in subsection 7.1.1.3.

— 7.1.1.5. For purposes of the preceding sentence, a legal adoption shall be considered as though it establishes a blood relationship between an adopted child and parent.

— 7.2. Request — A participant may request that a beneficiary be substituted by submitting to the program administrator a request to substitute beneficiary. The request shall accompany evidence, as specified by the program administrator, that the proposed substitute beneficiary is a member of the family of the beneficiary.

R765-685-8. Cancellation and Payment of Refunds.

— Purpose — Section 53B-8a-108 provides that any participant may cancel a participation agreement at will. This rule establishes the criteria for canceling participation agreements and providing refunds.

— 8.1. Cancellation — A participant may at any time cancel a participation agreement, without cause, by submitting to the program administrator notice to terminate agreement.

— 8.2. Payment of Refund — If the participation agreement is canceled, the participant is entitled to a refund. The refund shall be mailed or otherwise sent to the participant within sixty days after receipt by the program administrator of notice to terminate the participation agreement. The amount of the refund shall be the total of all contributions made plus actual investment income (including capital appreciation or depreciation) on the contributions, up to the current account balance as adjusted for any market change.

— 8.3. Death or Disability of the Beneficiary, Receipt of a Scholarship, or Rollover Distribution — The participant is entitled to a refund of one hundred percent of all payments made under the participation agreement plus all investment income which has been credited to the participant's account less any market loss and any amount paid by the trust for educational expenses of the beneficiary upon the occurrence of, 1) death of the beneficiary, 2) permanent disability or mental incapacity of the beneficiary, 3) receipt of a scholarship (or allowance or payment described in section 135(d)(1)(B) or (C) of the Internal Revenue Code) by the designated beneficiary to the extent the amount of the distribution does not exceed the amount of the scholarship, allowance, or payment, or 4) a rollover distribution to another program or account qualifying under Section 529 of the Internal Revenue Code. Under such circumstances, no administrative fee shall be charged.

— 8.3.1. Before a cancellation and refund due to the death of a beneficiary is made, a participant must provide the trust a copy of the beneficiary's death certificate or other proof of death acceptable under state law.

— 8.3.2. Before a cancellation and refund due to the disability or mental incapacity of a beneficiary is made, a participant must provide to the trust written certification from a qualified and licensed physician that the beneficiary cannot reasonably attend school.

— 8.3.3. Before a cancellation and refund due to the receipt of a scholarship, allowance or payment, a participant must provide to the trust written proof of the receipt by the beneficiary of a scholarship, allowance or payment and the amount thereof.

— 8.4. Refunds Reported— Funds that are refunded to a participant pursuant to this section shall be reported to the appropriate taxing authorities for the tax year in which such refund is made.

R765-685-9. Vested Participation Agreement.

— Purpose— Section 53B-8a-106 provides that the beneficiary of a vested participation agreement shall be considered a Utah resident for tuition purposes. This rule establishes the criteria for determining whether a participation agreement has vested.

— 9.1. Residency Requirement— An individual who has at any time been a resident of the State of Utah for at least eight continuous years and was designated as a beneficiary under a participation agreement for that entire eight year period, shall be deemed to have a vested participation agreement, even if the beneficiary leaves the state prior to enrollment in an institution of higher education.

— 9.2. Proof of Residency— At any time following the expiration of the period of eight years of continuous residency by the beneficiary, either the participant or the beneficiary may submit to the program administrator evidence of the residency for the purpose of establishing the vested participation agreement.

— 9.2.1. Evidence submitted on behalf of a dependent person shall pertain to the domicile of either parent during the claimed period of residency. Evidence submitted on behalf of an independent person shall pertain to the domicile of such person during the claimed period of residency.

— 9.2.2. The determination of residency shall be based upon verifiable circumstances or actions. No single fact is paramount, and each situation shall be evaluated to identify those facts which are essential to the determination of domicile.

— 9.2.3. The following facts, although not conclusive shall have probative value in support of a claim for resident classification.

— 9.2.3.1. Full time employment in Utah or transfer to an employer in contiguous area while maintaining domicile in Utah.

— 9.2.3.2. Filing of Utah resident income tax return for each applicable calendar year of claimed residency status.

— 9.2.3.3. Attendance as a full time, nonresident student at an out-of-state institution of higher education while determined to be a resident of Utah.

— 9.2.3.4. Abandonment of a former domicile and establishing domicile in Utah with attendance at an institution of higher education following and only incidental to such change in domicile.

— 9.2.3.5. Payment of occupational taxes in Utah.

— 9.2.3.6. Payment of real property taxes in Utah.

— 9.2.3.7. Payment of intangible personal property taxes in Utah.

— 9.2.3.8. Ownership of real property in Utah, if the property was used as a residence during the claimed period of residency.

— 9.2.3.9. Long term lease of housing during the claimed period of residency.

— 9.2.3.10. Utah automobile registration during the claimed period of residency.

— 9.2.3.11. Utah driver's license during the claimed period of residency.

— 9.2.3.12. Registration as a Utah voter during the claimed period of residency.

— 9.2.3.13. Corroborating affidavit of a non relative.

— 9.2.4. The determination of residency shall be based upon verifiable circumstances or actions and authenticated copies of relevant documentation. The program administrator may request additional documentation to clarify circumstances and formulate a decision that considers all relevant facts.

— 9.3. Non transferability— Although the participant may freely substitute beneficiaries under a participation agreement, the residency status acquired by a beneficiary of a vested participation agreement shall not be used to confer such status on a substitute beneficiary, nor shall the residency of one beneficiary be taken into account in the establishment of a vestment period of substitute beneficiary.

R765-685-10. Payment of Benefits.

— Purpose— Section 53B-8a-106 provides that payment of benefits provided under participation agreements must begin not later than the first full academic quarter or semester at an institution of higher education following the beneficiary's 22nd birthday or high school graduation, whichever ever is later, unless the participant notifies the program administrator to the contrary. This rule establishes the procedures for the payment of benefits.

— 10.1. Distribution of Benefits— For payment of benefits from the trust to begin, the participant shall submit a notice to use trust benefits.

— 10.2. Delay of Distribution— For payment of benefits to be delayed beyond four months after the beneficiary's 22nd birthday, the participant must submit a notice to delay trust benefits unless the beneficiary was over the age of 18 when the account was established. If no such notice is submitted, the program administrator shall refund money held by the trust on behalf of the participant according to section 8 of this rule.

— 10.3. Limit on Delay of Distribution— Participants may delay the distribution of trust benefits until the beneficiary's 27th birthday or for ten years from the date the account was established if the beneficiary was over the age of 18 at the date of establishment. If the participant does not submit a notice to use trust benefits on or before beneficiary's 27th birthday or ten years from the date of account establishment and the participant does not elect to roll the funds into another family member account or to substitute a beneficiary, the program administrator shall refund money held by the trust on behalf of the participant according to section 8 of this rule.

— 10.3.1. The program administrator may waive the age or time limit identified in subsection 10.3 of this rule if, in the judgement of the program administrator, the probability that the beneficiary will attend a higher education institution in the near future is significant.

— 10.4. Payout Schedule— Upon submission of a notice to use trust benefits, the participant shall specify the level of benefits to be paid. The participant may elect distribution of an allotment of the account balance, calculated by dividing the account balance by the number of academic periods in the beneficiary's program of study, or a higher amount, which shall not exceed the beneficiary's higher education costs for each academic period. The participant may adjust the level of benefits paid in any academic period by notifying the program administrator in writing.

~~—10.5. Duration of Payout—Distribution of benefits shall begin after receipt by the program administrator of notice to use trust benefits and shall continue throughout the beneficiary's period of enrollment at an institution of higher education or until the account balance has been exhausted, whichever occurs first.~~

~~—10.6. Interruption in Attendance—If following the submission of a notice to use trust benefits, the beneficiary interrupts his or her attendance at an institution of higher education, the participant shall submit a notice to delay trust benefits specifying the period for which trust benefits shall be delayed.~~

~~—10.7. Unused Benefits—If the beneficiary graduates from an institution of higher education, and a balance remains in the beneficiary's account, the program administrator shall refund the balance of the payments and the earnings from the investments in the program fund remaining in the account to the participant. The program administrator shall make the payment from the program fund within sixty days from the date of the beneficiary's graduation. The refund shall be made unless the beneficiary plans to continue at a higher education institution and the participant submits a completed notice to delay benefits or notice to use trust benefits.~~

~~—10.8. Refunds Reported—Funds that are refunded to a participant pursuant to this section shall be reported to the appropriate taxing authorities for the tax year in which such refund is made.~~

R765-685-11. Higher Education Costs.

~~—Purpose—Section 53B-8a-101 authorizes the establishment of the Utah Educational Savings Plan Trust to encourage individuals to save for future higher education costs. This rule established the definition of higher education costs.~~

~~—11.1. Definition—The term "higher education costs" shall mean charges for tuition, fees, books, supplies and equipment required for enrollment or attendance of a designated beneficiary at an institution of higher education.~~

~~—11.2. Payment of Benefits—The payment of benefits pursuant to subsection 10 of this rule may be made only for higher education costs as defined in subsection 11.1.~~

R765-685-12. Investment Policy.

~~—Purpose—This rule is applicable to all investments by the Utah Educational Savings Plan Trust and to Trustees for funds covered by Trust agreements.~~

~~—12.1. Investment Objectives—The primary objectives, in priority order, of investment activities shall be:~~

~~—12.1.1. to provide compliance with the State Money Management Act and related Rules;~~

~~—12.1.2. to provide adequate liquidity levels to meet Trust obligations;~~

~~—12.1.3. to provide guidelines as to the types and maturities of investments while considering: (a) the availability of funds to cover current needs; (b) maximum yields on investments of funds, and (c) minimum exposure to risk of loss.~~

~~—12.1.4. All fixed income investments will be suitable to be held to maturity; however, sale prior to maturity may be necessary and warranted in some cases. The Trust's investment portfolio will not be used for speculative purposes.~~

~~—12.1.5. The public treasurer will consider and meet the following objectives when investing Trust funds:~~

~~—12.1.5.1. safety of principal;~~

~~—12.1.5.2. need for liquidity;~~

~~—12.1.5.3. yield on investments;~~

~~—12.1.5.4. recognition of the different investment objectives of Program, Endowment and Administrative Funds; and~~

~~—12.1.5.5. maturity of investments, so that the maturity date of the investment does not exceed the anticipated date of the expenditure of funds.~~

~~—12.2. Standards of Care—Standards of care include:~~

~~—12.2.1. Prudence—Selection of investments as authorized by this policy shall be made with the exercise of that degree of judgment and care, under circumstances then prevailing, which a person of prudence, discretion, and intelligence would exercise in the management of his or her own affairs, not for speculation but for investment, considering the probable safety of capital, as well as the probable benefits to be derived and the probable duration for which such investment may be made, and considering the investment objectives specified in this policy.~~

~~—12.2.2. Ethics and Conflicts of Interest—Officers and employees involved in the investment process shall refrain from personal business activity that could conflict with the proper execution and management of the investment program, or that could impair their ability to make impartial decisions. Employees and investment officials shall disclose any personal financial or investment positions that could be related to the performance of the investment in accordance with Utah Code Annotated 67-16-1, Utah Public Officer's and Employees' Ethics Act.~~

~~—12.2.3. Delegation of Authority—Authority to manage the investment program is granted to the Trust's public treasurer who is responsible for the operation of the investment program and who shall carry out established written procedures and internal controls for the operation of the investment program consistent with this investment policy.~~

~~—12.3. Safekeeping and Custody—Standards of safekeeping and custody shall include:~~

~~—12.3.1. Internal Controls—The public treasurer is responsible for establishing and maintaining an internal control structure designed to ensure that the assets of the Trust are protected from loss, theft or misuse. The internal control structure shall be designed to provide reasonable assurance that these objectives are met.~~

~~—12.3.1.1. Accordingly, the public treasurer shall establish a process for an annual independent review as provided by the state auditor to assure compliance with policies and procedures.~~

~~—12.3.2. Custody—~~

~~—12.3.2.1. The public treasurer shall have custody of all securities purchased or held and all evidence of deposits and investments of all funds. All securities shall be delivered versus payment to the public treasurer or to the treasurer's safekeeping bank.~~

~~—12.3.2.2. The public treasurer may deposit any of these securities with a bank or trust company to be held in safekeeping by that custodian.~~

~~—12.3.2.3. The provisions of this subsection apply to any book-entry only security the ownership records of which are maintained with a securities depository, in the Federal Book Entry system authorized by the U.S. Department of Treasury, or in the book-entry records of the issuer, as follows:~~

~~—12.3.2.3.1. the direct ownership of the security by the public treasurer shall be reflected in the book-entry records and represented by a receipt, confirmation, or statement issued to the public treasurer by the custodian of the book-entry system; or~~

~~—12.3.2.3.2. the ownership of the security held by the public treasurer's custodial bank or trust company shall be reflected in the book-entry records and the public treasurer's ownership shall be~~

represented by a receipt, confirmation, or statement issued by the custodial bank or trust company.

—12.3.3. All investments shall be approved by the State Treasurer.

—12.4. Authorized Investments—Investment transactions may be conducted only through qualified depositories, certified dealers, or directly with the issuers of the investment securities. The remaining term to maturity of investments may not exceed the period of availability of the funds to be invested. Deposits into the Trust's Administrative Fund and Program Fund may be invested only in assets that meet the Trust's investment objectives and criteria and the requirements of the State Money Management Act as amended, including the State Public Treasurer's Investment Fund, equity securities, such as common and preferred stock issued by corporations listed on a major securities exchange and mutual funds or such equity securities, and bonds or other fixed-income securities issued by domestic corporations rated A or higher or by the United States, the State of Utah, or a political subdivision thereof.

—12.5. Reporting—The public treasurer will prepare monthly and quarterly investment reports with appropriate assertions which will be submitted to the Utah State Board of Regents Student Finance Subcommittee for review and approval. The Subcommittee will determine the format and information to be reported.

R765-685-13. Earnings in Program Fund.

—Purpose—Section 53B-8a-107 provides the Trust with authority to invest, via the program fund, payments made by a participant under a participation agreement. This rule establishes the terms for the payment of interest, dividends, and market adjustments to individual participant accounts within the program fund.

—13.1. Quarterly Crediting—The trust shall credit interest or dividend earnings and make positive or negative market adjustments from the program fund to individual participant accounts at least on a quarterly basis.

—13.2. Pro rata Share—A pro rata share of interest or dividends earned by the program fund during a given quarter shall be credited to each participant account at the end of the quarter. The pro rata amount posted to each individual account shall be based on the average daily balance of the individual account compared to the average daily balance of the program fund during the quarter.

—13.3. Transfers to Administrative Fund—Upon approval of the board, up to .5 percentage points of interest earned annually in the program fund may be transferred to the administrative fund for administrative purposes.

—13.4. Quarterly Statement—At the close of each quarter, the Trust shall provide for each participant a statement listing the beginning balance, interest or dividends earned, positive or negative adjustments to market value, and closing balance of the participant's account held in the program fund.

R765-685-14. Earnings in Endowment Fund.

—Purpose—Section 53B-8a-107 provides that each beneficiary for whom funds are saved under a participation agreement shall receive an interest in a portion of the investment income of the endowment fund of the Trust. This rule provides for implementation of this provision:

—14.1. Transfers to Administrative Fund—Upon approval of the board, up to two percentage points of interest earned annually in the endowment fund may be transferred to the administrative fund for administrative purposes.

—14.2. Earmarking of Endowment Interest—A portion of the interest earned by the endowment fund that is not transferred to the administrative fund shall be earmarked for use by the beneficiary of each participation agreement.

—14.3. Pro rata Share—Each quarter, a pro rata amount of endowment fund interest shall be earmarked to each participant account eligible under any restrictions imposed by a donor on contributions to the Endowment Fund. The pro rata amount shall be based on the average daily balance of the eligible account held on behalf of a beneficiary in the program fund compared to the average daily balance of all eligible accounts in the entire program fund during the quarter, up to an amount equal to .25 percent of the amount saved on behalf of the beneficiary in such account.

—14.4. The earmarking of endowment interest for use by a beneficiary shall not constitute ownership of such interest on the part of any beneficiary or participant. Upon cancellation of a participation agreement, endowment interest earmarked to an account shall revert back to the endowment fund.

—14.5. Reinvestment of Endowment Interest—Endowment interest that is not either transferred to the administrative fund or earmarked for use by a beneficiary under a program agreement shall be reinvested in the endowment fund.

—14.6. Quarterly Disclosure—The quarterly statement provided to each participant by the Trust shall disclose both the quarterly and cumulative amounts of endowment interest that have been earmarked for use by a beneficiary under a participation agreement.

—14.7. Payment of Benefits—When payment of benefits for the beneficiary begin under a participation agreement, interest from the endowment fund that has been earmarked for use by the beneficiary shall be made available for higher education costs, and shall be disbursed with the principal and interest held on behalf of the beneficiary in the program fund according to section 10 of this rule.

R765-685-15. No Pledging of Trust Funds as Security.

—15.1. Funds held by the Utah Educational Savings Plan Trust may not be used by a participant or a beneficiary under a participation agreement as security for a loan.

**KEY: higher education, educational savings trust
August 1, 2003
Notice of Continuation November 30, 2001
53B-8a]**



Tax Commission, Auditing
R865-19S-90
Telephone Service Pursuant to Utah
Code Ann. Section 59-12-103

NOTICE OF PROPOSED RULE (Amendment)

DAR FILE NO.: 28049
FILED: 06/28/2005, 13:54

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: S.B. 127 (2005) amended Section 59-12-103 to indicate the sales tax treatment of repairs. (DAR NOTE: S.B. 127 is found at UT L 2005 Ch 158, and was effective 07/01/2005.)

SUMMARY OF THE RULE OR CHANGE: The proposed amendment deletes language indicating the sales tax treatment of repairs since that language is now in statute.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 59-12-103

ANTICIPATED COST OR SAVINGS TO:

- ❖ THE STATE BUDGET: Any impact was taken into account in the fiscal note to S.B. 127 (2005).
- ❖ LOCAL GOVERNMENTS: Any impact was taken into account in the fiscal note to S.B. 127 (2005).
- ❖ OTHER PERSONS: Any impact was taken into account in the fiscal note to S.B. 127 (2005).

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--Language is deleted since it now appears in statute.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no impact on businesses. Pam Hendrickson, Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

TAX COMMISSION
AUDITING
210 N 1950 W
SALT LAKE CITY UT 84134, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Cheryl Lee at the above address, by phone at 801-297-3900, by FAX at 801-297-3919, or by Internet E-mail at clee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: Pam Hendrickson, Commission Chair

R865. Tax Commission, Auditing.**R865-19S. Sales and Use Tax.****R865-19S-90. Telephone Service Pursuant to Utah Code Ann. Section 59-12-103.**

A. Definitions.

1. "Interstate" means a transmission that originates in this state but terminates in another state, or a transmission that originates in another state but terminates in this state.

2. "Intrastate" means a transmission that originates and terminates in this state, even if the route of the transmission signal itself leaves and reenters the state. Prepaid telephone services or service contracts are presumed to be used for intrastate telephone services unless the service contract is sold exclusively for use in interstate communications.

3. "Two-way transmission" includes any services provided over a public switched network.

B. Taxable telephone service charges include:

1. subscriber access fees;

2. charges for optional telephone features, such as call waiting, caller ID, and call forwarding; and

3. nonrecurring charges that are ordinarily charged to subscribers only once or only under exceptional circumstances, including charges to:

a) establish, change, or disconnect telephone service or optional features; and

b) ~~install or~~ repair telephone equipment that retains its character as tangible personal property.

C. Nontaxable charges include:

1. refundable subscriber deposits, interest, and late payment penalties;

2. charges for interstate long distance or toll calls;

3. telephone answering services received or relayed by a human operator;

4. charges to ~~install or~~ repair subscriber equipment that is regarded as real property;

5. charges levied on subscribers to fund or subsidize special telephone services, including 911 service, special communications services for the deaf, and special telephone service for low income subscribers;

6. contributions in aid of construction, land development fees, payments in lieu of land development fees, and special plant construction and relocation charges; and

7. charges for one-way pager services.

KEY: charities, tax exemptions, religious activities, sales tax 2005

**Notice of Continuation April 5, 2002
59-12-103**

**Tax Commission, Auditing****R865-19S-98**

Sales to Nonresidents of Vehicles, Off-highway Vehicles, and Boats Required to be Registered, and Sales to Nonresidents of Boat Trailers and Outboard Motors Pursuant to Utah Code Ann. 59-12-104

NOTICE OF PROPOSED RULE

(Amendment)

DAR FILE NO.: 28050

FILED: 06/28/2005, 15:13

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Although there is a sales tax exemption for certain vehicles purchased by nonresidents, there is no statutory definition of nonresident. The current rule definition of nonresident appears to be narrower than statute would allow.

SUMMARY OF THE RULE OR CHANGE: The proposed amendment provides that a person may own a residence in Utah and still qualify as a nonresident so long as that person does not occupy the residence; and provides that failure to meet the rule criteria is a rebuttable presumption that the exemption does not apply.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 59-12-104

ANTICIPATED COST OR SAVINGS TO:

- ❖ THE STATE BUDGET: Immaterial cost since the amendments will slightly broaden the exemption to persons who own property in this state, so long as they don't occupy the property.
- ❖ LOCAL GOVERNMENTS: Immaterial cost since the amendments will slightly broaden the exemption to persons who own property in this state, so long as they don't occupy the property.
- ❖ OTHER PERSONS: Immaterial savings since the amendment will slightly broaden the exemption to persons who own property in this state, so long as they don't own property.

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--The amendment will allow people who own, but do not occupy property in this state to claim the exemption.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Since this amendment broadens the exemption slightly more than the rule currently in place, there is the possibility that more people will qualify for the nonresident exemption. Pam Hendrickson, Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

TAX COMMISSION
AUDITING
210 N 1950 W
SALT LAKE CITY UT 84134, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Cheryl Lee at the above address, by phone at 801-297-3900, by FAX at 801-297-3919, or by Internet E-mail at clee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: Pam Hendrickson, Commission Chair

R865. Tax Commission, Auditing.**R865-19S. Sales and Use Tax.****R865-19S-98. Sales to Nonresidents of Vehicles, Off-highway Vehicles, and Boats Required to be Registered, and Sales to Nonresidents of Boat Trailers and Outboard Motors Pursuant to Utah Code Ann. Section 59-12-104.**

~~[A-](1)~~ "Use" means mooring, slipping, and dry storage as well as the actual operation of vehicles.

~~[B-](2)~~ In order to qualify as a nonresident for the purpose of exempting vehicles from sales tax under Subsections 59-12-104(9) and 59-12-104(31), a person vehicle owner may not:

~~1.~~ be a resident of this state. The fact that a person leaves the state temporarily is not sufficient to terminate residency;

~~2.~~(a) be engaged in intrastate business within this state;

~~3.~~(b) maintain a vehicle with this state designated as the home state;

~~4.~~(c) except in the case of a tourist temporarily within this state, own, lease, or rent a residence or a place of business within this state, or occupy or permit to be occupied a Utah residence or place of business];

~~(d)~~ operate an interstate business that occupies real property within the state;

~~5.~~(e) except in the case of an employee who can clearly demonstrate that the use of the vehicle in this state is to commute to work from another state, be engaged in a trade, profession, or occupation or accept gainful employment in this state;

~~6.~~(f) allow the purchased vehicle to be kept or used by a resident of this state; or

~~7.~~(g) declare residency in Utah to obtain privileges not ordinarily extended to nonresidents, such as attending school or placing children in school without paying nonresident tuition or fees, or maintaining a Utah driver's license.

(3) The fact that a resident leaves the state temporarily is not sufficient to terminate residency.

~~[C-](4)~~ A nonresident owner of a vehicle described in Section 59-12-104(9) may continue to qualify for the exemption provided by that section if use of the vehicle in this state is infrequent, occasional, and nonbusiness in nature.

~~[D-](5)~~ A nonresident owner of a vehicle described in Subsection 59-12-104(31) may continue to qualify for the exemption provided by that section if use of the vehicle in this state does not exceed 14 days in any calendar year and is nonbusiness in nature.

~~[E-](6)~~ Vehicles are deemed not used in this state beyond the necessity of transporting them to the borders of this state if purchased by:

~~1.~~(a) a nonresident student who will be permanently leaving the state within 30 days of the date of purchase; or

~~2.~~(b) a nonresident member of the military stationed in Utah, but with orders to leave the state permanently within 30 days of the date of purchase.

(7)(a) Except as provided in Subsection (7)(b), there is a rebuttable presumption that a vehicle owner may not receive the sales tax exemption described in Subsections 59-12-104(9) or (31) if a vehicle owner does not satisfy:

(i) the requirements of a nonresident under Subsections R865-19S-98(2) and (3); and

(ii) the use limitations under Subsections R865-19S-98(4)-(6).
 (b) Notwithstanding Subsection (7)(a), the commission may, pursuant to an appeal filed under Title 63, Chapter 46b, Administrative Procedures Act, allow an exemption to a vehicle owner if the vehicle owner presents evidence that the sales tax exemption under Subsections 59-12-104(9) or (31) should apply.

[F-](8) Each purchaser, both buyer and co-buyer, claiming this exemption must complete a nonresident affidavit. False, misleading, or incomplete responses shall invalidate the affidavit and subject the purchaser to tax, penalties, and interest.

[G-](9) A dealer of vehicles who accepts an incomplete affidavit, may be held liable for the appropriate tax, interest, and penalties.

[H-](10) A dealer of vehicles who accepts an affidavit with information that the dealer knows or should have known is false, misleading or inappropriate may be held liable for the appropriate tax, interest, and penalties.

KEY: charities, tax exemptions, religious activities, sales tax
~~December 21, 2004~~2005
 Notice of Continuation April 5, 2002
 59-12-104



Tax Commission, Motor Vehicle
R873-22M-27
 Issuance of Special Group License
 Plates Pursuant to Utah Code Ann.
 Sections 41-1a-418, 41-1a-419, 41-1a-
 420, and 41-1a-421

NOTICE OF PROPOSED RULE

(Amendment)
 DAR FILE NO.: 28046
 FILED: 06/28/2005, 10:56

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The section is amended to reinsert language inadvertently deleted in a recent amendment to the rule.

SUMMARY OF THE RULE OR CHANGE: The proposed amendment reinserts language indicating the evidence an applicant must provide to receive former prisoner of war special group license plates.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 41-1a-418 and 41a-1a-421

ANTICIPATED COST OR SAVINGS TO:

❖ **THE STATE BUDGET:** None--This language has been in the rule since the plate was authorized. The recent deletion was inadvertent and adding it back in involves no costs.
 ❖ **LOCAL GOVERNMENTS:** None--This language has been in the rule since the plate was authorized. The recent deletion was inadvertent and adding it back in involves no costs.

❖ **OTHER PERSONS:** None--This language has been in the rule since the plate was authorized. The recent deletion was inadvertent and adding it back in involves no costs.

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--The amendment reinserts language that was inadvertently repealed in a recent amendment and adding it back in involves no costs.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no impact on businesses. Pam Hendrickson, Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

TAX COMMISSION
 MOTOR VEHICLE
 210 N 1950 W
 SALT LAKE CITY UT 84134, or
 at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Cheryl Lee at the above address, by phone at 801-297-3900, by FAX at 801-297-3919, or by Internet E-mail at clee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: Pam Hendrickson, Commission Chair

R873. Tax Commission, Motor Vehicle.

R873-22M. Motor Vehicle.

R873-22M-27. Issuance of Special Group License Plates Pursuant to Utah Code Ann. Sections 41-1a-418, 41-1a-419, 41-1a-420, and 41-1a-421.

(1) Except as otherwise provided, a special group license plate shall consist of a symbol affixed to the left-hand side of the plate, followed by five characters. The first four characters shall be numbers and the fifth shall be a letter.

(2) (a) Legislature special group license plates shall carry the letter combination SEN or REP with the number of the district from which the legislator was elected or appointed.

(b) A state legislator may register a maximum of two vehicles with Legislature special group license plates.

(c) Upon leaving office, a legislator may not display the Legislature special group license plates on any motor vehicle. Legislators not reelected to office may not display the Legislature special group license plates after December 31 of the election year.

(3) (a) United States Congress special group license plates shall carry, in the case of representatives, the letter combination HR, followed by the number of the district from which the representative was elected or appointed, or, in the case of senators, USS 1 or USS 2, signifying the senior and junior senators.

(b) Upon leaving office, a member of Congress may not display United States Congress special group license plates on any motor vehicle. A member of Congress not reelected to office may not display United States Congress special group license plates after December 31 of the election year.

(4) Survivor of the Japanese attack on Pearl Harbor special group license plates may be issued to qualified U.S. military veterans who:

(a) provide a copy of their discharge papers, notice of separation, or other government issued document acceptable to the division verifying dates and locations of active service; or

(b) present evidence of membership in the Pearl Harbor Survivors Association.

(5) Former prisoner of war special group license plates shall be issued to qualified U.S. military veterans who provide a copy of their discharge papers, notice of separation, or other government issued document acceptable to the division indicating that the veteran was classified as a prisoner of war.

(6) Recipient of a purple heart special group license plates shall be issued to qualified U.S. military veterans who:

(a) provide a copy of their discharge papers, notice of separation, or other government issued document acceptable to the division indicating the veteran was awarded the purple heart; or

(b) present evidence of current membership in the Military Order of the Purple Heart.

(7) An applicant for a National Guard special group license plate must present a current military identification card that shows active membership in the Utah National Guard.

(8) The issuance, renewal, surrender, and design of disability special group license plates and windshield placards shall be subject to the provisions of the federal Uniform System for Parking for Persons with Disabilities, 23 C.F.R. Ch. 11, Subch. B, Pt. 1235.2 (1991), which is adopted and incorporated by reference.

(9)(a) An applicant for a licensed amateur radio operator special group license plate shall present a current Federal Communication Commission (FCC) license.

(b) The license plate number for a licensed amateur radio operator special group license plate shall be the same combination of alpha and numeric characters that comprise the FCC assigned radio call letters of the licensed operator.

(c) Only one set of licensed amateur radio operator special group license plates may be issued per FCC license.

(10) A farm truck special group license plate may be issued for a vehicle that is qualified to register as a farm truck under Section 41-1a-1206.

(11) (a) To qualify for a firefighter special group license plate, an applicant must present one of the following:

(i) evidence indicating the applicant has a current membership in the Utah Firefighters' Association;

(ii) an official identification card issued by the firefighting entity identifying the applicant as an employee or volunteer of that firefighting entity;

(iii) a letter on letterhead of the firefighting entity, or the municipality or county in which the firefighting entity is located, identifying the applicant as an employee or volunteer of that firefighting entity; or

(iv) a letter on letterhead from a firefighting entity, or the municipality or county in which the firefighting entity is located, identifying the applicant as a retired firefighter, whether employed or volunteer, of that firefighting entity.

(b) The division shall revoke a firefighter special group license plate issued under Section 41-1a-418 upon receipt of written notification from the head of a firefighting entity indicating:

(i) the name of the individual whose license plate is revoked;

(ii) the license plate number that is revoked;

(iii) the reason the license plate is revoked; and

(iv) that the firefighting entity has notified the individual described in Subsection (11)(b)(i) that the license plate will be revoked.

(12) An individual who no longer qualifies for the particular special group license plate may not display that special group license plate on any motor vehicle and must reregister the vehicle and obtain new license plates.

KEY: taxation, motor vehicles, aircraft, license plates 2005

Notice of Continuation April 5, 2002

41-1a-418

41-1a-419

41-1a-420

41-1a-421

▼ ————— ▼

Workforce Services, Employment Development **R986-600** Workforce Investment Act

NOTICE OF PROPOSED RULE (Amendment)

DAR FILE NO.: 28063

FILED: 07/01/2005, 12:58

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this amendment is to streamline eligibility and bring it closer to federal requirements.

SUMMARY OF THE RULE OR CHANGE: This proposed amendment is intended to make it easier to apply for Workforce Investment Act (WIA) intensive and training services. The requirements for obtaining services remain essentially the same and are in compliance with federal guidelines. The suitable employment requirement is changed to reflect the language in the federal regulations of achieving self-sufficiency which is easier to determine. The requirements for appropriateness of training and need remain the same. Some wording was changed to make the rules easier to understand.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsections 35A-1-104(1) and 35A-1-104(4)

ANTICIPATED COST OR SAVINGS TO:

❖ **THE STATE BUDGET:** This is a federally-funded program so there are no costs or savings to the state budget.

❖ **LOCAL GOVERNMENTS:** This rule does not apply to local government so therefore, there are no costs or savings to local governments. Local governments do not contribute to the costs of this program.

❖ OTHER PERSONS: There are no costs or savings to any other persons as there are no fees associated with this program and it is federally funded. Some individuals who did not meet the suitable employment requirement or 80% income requirement may now be eligible under the self-sufficiency standard.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no costs or savings to any affected persons as there are no fees associated with this program and it is federally funded.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There are no compliance costs associated with this change. There are no fees associated with this change. It will not cost anyone any sum to comply with these changes. Tani Downing, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

WORKFORCE SERVICES
EMPLOYMENT DEVELOPMENT
140 E 300 S
SALT LAKE CITY UT 84111-2333, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Suzan Pixton at the above address, by phone at 801-526-9645, by FAX at 801-526-9211, or by Internet E-mail at spixton@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: Tani Downing, Executive Director

R986. Workforce Services, Employment Development.

R986-600. Workforce Investment Act.

R986-600-602. Workforce Investment Act (WIA).

(1) The goal of WIA is to increase a customer's occupational skills, employment, retention and earnings; to decrease welfare dependency; and to improve the quality of the workforce and national productivity.

(2) WIA is for individuals who need assistance finding ~~suitable~~ employment to achieve self-sufficiency.

(3) Services are available for the following groups: adult, dislocated workers, and youth services.

R986-600-606. Intensive Services.

(1) ~~[If the client establishes appropriateness and need,]~~ Intensive services are available to adults and dislocated workers:

(a) who are unemployed, ~~registered at an Employment Center, and who desire employment~~ ~~[and are unable to obtain 'suitable employment' through core services and who have been determined by a Department employment counselor to be in need of more intensive services in order to obtain employment];~~ or

(b) who are employed, ~~[but who are determined by the Department to be in need of intensive services in order to obtain or~~

~~retain suitable employment. Suitable employment is employment that allows for self-sufficiency. Self-sufficiency for WIA is generally determined to be 200% of the Office of Management and Budget poverty level.]~~ registered at an Employment Center, meet the self-sufficiency definition, and need to improve or change their current employment status. Self-sufficiency for WIA is defined as:

~~(i) declared income from the customer's primary job is less than the WIA income eligibility standards as found in R986-600-617(4) for a family of eight; or~~

~~(ii) the customer is at risk of losing his or her current level of income as evidenced by:~~

~~(A) a notice of lay-off or closure,~~

~~(B) the inability to retain his or her current job due to changes such as the requirement for increased skills,~~

~~(C) technological or industry changes, or~~

~~(D) the potential future income from the customer's primary job will be less than the WIA income eligibility standards for a family of eight.~~

(2) Intensive services are available to youth who:

(a) establish appropriateness and need, and
(b) require additional assistance to complete an educational program or to secure and hold employment, and
(c) meet the regional service priority level.

(3) intensive services for adults, dislocated workers and youth consist of:

(a) an assessment as provided in R986-600-620,
(b) development of an employment plan as provided in R986-600-621.

(c) Short-term prevocational services, including development of learning skills, communication skills, interviewing skills, punctuality, personal maintenance skills, and professional conduct, to prepare individuals for unsubsidized employment or training,

(d) case management, counseling and career planning, and
(e) supportive services.

(4) Additional intensive services available to youth include:

(a) leadership development,
(b) mentoring,
(c) comprehensive guidance and counseling, and
(d) follow-up services.

R986-600-607. Training Services.

(1) If the client establishes appropriateness and need, training services are available to adults and dislocated workers:

(a) who are unemployed and are unable to ~~[obtain 'suitable employment']~~ achieve self-sufficiency through intensive services, ~~[and who have been determined by a Department employment counselor to be in need of training services in order to obtain suitable employment; or~~

~~(b) who are employed, but who are determined by the Department to be in need of training services in order to obtain or retain suitable employment as defined in R986-600-606(2).~~

~~(2) The employment counselor determines what is suitable employment based on the customer's individual circumstances.]~~

~~(3)~~ Training services include employment related education and work site learning.

~~(4)~~ Training services are available to youth who:

(a) establish appropriateness and need, and
(b) require additional assistance to complete an educational program or to secure and hold employment, and
(c) meet the regional service priority level.

~~(5)~~ Training services for youth consist of;

- (a) tutoring,
- (b) alternative school,
- (c) occupational skills training,
- (d) paid and unpaid internships, and/or
- (e) summer youth employment opportunities.

R986-600-611. Income Eligibility Requirements.

(1) Applicants for all youth and adult programs must meet the income eligibility requirements in this rule.

(2) Dislocated workers do not need to meet income eligibility requirements ~~however appropriate training is only available if the dislocated worker is unable to obtain or retain~~

- ~~(a) employment at 80% or more of his or her lay off wage, or~~
- ~~(b) suitable employment as defined in this rule.~~

R986-600-612. Prioritization Factors Used for Determining Eligibility for Adult and Dislocated Workers.

(1) For adults and dislocated workers, in addition to meeting the eligibility requirements found in rules R996-600-608 through R996-600-611, the Department will prioritize clients' eligibility based on prioritization factors developed by the Department. Current prioritization factors are available at the Department. When a client is approved for intensive or training services, the Department will estimate the anticipated cost to the Department associated with that services and "obligate" and reserve that amount for accounting purposes. The total amount of money obligated and reserved will determine which prioritization factors are operational at any given time.

~~(2) A dislocated worker can only get funding if he or she cannot find a job paying 80% of the lay off wage or suitable employment as defined in this rule and they meet the Department's current prioritization factors.~~

~~(3)2~~ WIA Youth Councils set regional priority levels for services for youth based on the needs of youth in specific regions or sub-region areas.

~~(4)3~~ Because the funding is separate and distinct for each program, the prioritization factors operate independently for each of the two affected programs.

R986-600-614. How to Determine Who Is Included in the Family.

Family size must be determined to establish income eligibility for adult and youth services ~~and adults~~. Family size is determined by counting the maximum number of family members in the residence during the previous six months, not including the current month. Family size must be verified only if the Department is using family income to determine low-income eligibility for adult or youth services.

(1) A customer can be considered a "family" of one, if the customer is:

- (a) age 18 or older and living on his or her own;
- (b) emancipated;
- (c) an adult child, age 22 or older, living with his or her parents and applying on his or her own behalf; or
- (d) living alone or with a family and has a verifiable disability that is a substantial barrier to employment.

~~(1)2~~ A 'family' is generally described as two or more persons related by blood, marriage, or decree of court, living in a single residence, ~~and included in one or more of the following categories:~~ A dependent child is a child the parent or guardian claimed as a dependent of the parent or guardian's tax return.

(a) Family members included in the income determination:

~~(a)1~~ A husband and wife and dependent children age 21 and under;

~~(b)2~~ A parent or legal guardian and dependent children age 21 and under; or

~~(e)3~~ A husband and wife, if there are no dependent children.

~~(2) A single person or an adult child (age 22 or older) applying on their own behalf and living with parent(s) is considered a family of one. Dependent adult children are not included in determining family size if another household member is applying for services.~~

~~(3) b~~ "Living in a single residence" includes family members residing elsewhere on a voluntary, temporary basis, such as attending school or visiting relatives. It does not include involuntary temporary residence elsewhere, such as incarceration, or court-ordered placement outside the home.

~~(4) c~~ Two people living in a single residence but who are not married are not members of the same 'family'. If they have children together, for WIA reporting purposes, each is considered a single parent and the children are considered part of each persons family.

~~(5) Family size will be determined by counting the maximum number of family members in the residence during the last 6 months.~~

~~(6) Family size must be verified only if using family income to determine low income status for WIA adult or youth services.~~

~~(7) A family can only include two generations.~~

~~(8) A client with a disability that is a barrier to employment may be determined a family of one for determining family income.~~

R986-600-623. Education and Training and Support Services as Part of an Employment Plan.

(1) A client's participation in education or training beyond that required to obtain a high school diploma or its equivalent is limited per exposure to the lesser of:

(a) 24 months which need not be continuous and which can be waived by a Department supervisor based on individual circumstances, or

(b) the completion of the education and training goals of the employment plan.

(2) Education and training will only be supported where:

(a) the client is unable to ~~find suitable employment due to a lack of marketable skills~~ achieve self-sufficiency;

(b) the education or training will substantially increase the income level the client would be able to attain without the education or training;

(c) the plan must show that the client has the ability to be successful in the education or training and in the market thereafter;

(d) the education or training is required for the occupation;

(e) the client is willing to complete the education or training as quickly as is reasonable;

(f) the mental and physical health of the client indicates the education or training could be completed successfully and the client could perform the job once the schooling is completed; and

(g) the specific employment goal that requires the education or training is marketable in the area where the client resides or the client has agreed to relocate for the purpose of employment once the education/training is completed.

(3) Additional payments and/or services are allowable under certain circumstances based on individual need provided they are necessary and appropriate to enable the client to participate in activities authorized under this title (WIA).

R986-600-652. Determining Initial Eligibility for Training Providers.

(1) Training providers are automatically eligible if they if they complete an application and are either:

- (a) a postsecondary educational institution that:
 - (i) is eligible to receive federal funds under Title IV of the Higher Education Act of 1965 (20 U.S.C. 1070 et seq.), and
 - (ii) provides a program that leads to an associate degree, baccalaureate degree, or certificate; or

(b) an entity that provides programs under the "National Apprenticeship Act", 50 Stat. 664, chapter 663; 29 U.S.C. 50 et seq.

(2) All other training providers must submit the following information:

- (a) the name, mailing address, physical address, telephone number, and email address (if available) of the training facility;
- (b) documentation of financial stability of the applicant, which may include audits or financial statements or evidence of compliance with the Utah Board of Regents' bonding requirements;
- (c) the name of each program for which approval is requested;
- (d) the percentage of all participants who complete each program;
- (e) the percentage of all participants in each program who obtained unsubsidized employment;
- (f) average placement wage of all participants in each program;
- (g) if applicable, the rate of Utah state-recognized or industry-recognized licensure, certification, degrees, or equivalent attained by all program graduates. For example, CDL, Certified Nurse Aid, Licensed Practical Nurse, Novell Network Engineer;

(h) program costs including tuition and fees; [
~~(i) a description of the methodology used to collect and verify performance information;~~]

- (~~j~~) a copy of the provider's student grievance procedure;
- (~~k~~) the self-administered Department training provider accessibility checklist; and
- (~~l~~) the number of years in business using the current name, and a list of other names under which the provider operated.

(3) Applications from providers in paragraph 2 above will be sent to the Regional Council staff in the region in which the provider does business or wishes to apply. Regional Councils recommend approval or disapproval for each provider and these results are sent to the State Council for final action.

(4) Performance information must meet standards established by the Department or the state council may grant an exception.

(5) All schools must be in business for a minimum of one year before approval will be granted.

(6) The Department will notify a provider in writing when a decision has been made concerning the provider's eligibility.

(7) A list of Initially Eligible providers including program performance and cost information will be published on the Internet.

KEY: Workforce Investment Act

~~November 1, 2004~~ **2005**

35A-5



End of the Notices of Proposed Rules Section

NOTICES OF CHANGES IN PROPOSED RULES

After an agency has published a PROPOSED RULE in the *Utah State Bulletin*, it may receive public comment that requires the PROPOSED RULE to be altered before it goes into effect. A CHANGE IN PROPOSED RULE allows an agency to respond to comments it receives.

As with a PROPOSED RULE, a CHANGE IN PROPOSED RULE is preceded by a RULE ANALYSIS. This analysis provides summary information about the CHANGE IN PROPOSED RULE including the name of a contact person, anticipated cost impact of the rule, and legal cross-references.

Following the RULE ANALYSIS, the text of the CHANGE IN PROPOSED RULE is usually printed. The text shows only those changes made since the PROPOSED RULE was published in an earlier edition of the *Utah State Bulletin*. Additions made to the rule appear underlined (e.g., example). Deletions made to the rule appear struck out with brackets surrounding them (e.g., [example]). A row of dots in the text (.) indicates that unaffected text was removed to conserve space. If a CHANGE IN PROPOSED RULE is too long to print, the Division of Administrative Rules will include only the RULE ANALYSIS. A copy of rules that are too long to print is available from the agency or from the Division of Administrative Rules.

While a CHANGE IN PROPOSED RULE does not have a formal comment period, there is a 30-day waiting period during which interested parties may submit comments. The 30-day waiting period for CHANGES IN PROPOSED RULES published in this issue of the *Utah State Bulletin* ends August 15, 2005. At its option, the agency may hold public hearings.

From the end of the waiting period through November 12, 2005, the agency may notify the Division of Administrative Rules that it wants to make the CHANGE IN PROPOSED RULE effective. When an agency submits a NOTICE OF EFFECTIVE DATE for a CHANGE IN PROPOSED RULE, the PROPOSED RULE as amended by the CHANGE IN PROPOSED RULE becomes the effective rule. The agency sets the effective date. The date may be no fewer than 30 days nor more than 120 days after the publication date of this issue of the *Utah State Bulletin*. Alternatively, the agency may file another CHANGE IN PROPOSED RULE in response to additional comments received. If the Division of Administrative Rules does not receive a NOTICE OF EFFECTIVE DATE or another CHANGE IN PROPOSED RULE, the CHANGE IN PROPOSED RULE filing, along with its associated PROPOSED RULE, lapses and the agency must start the process over.

CHANGES IN PROPOSED RULES are governed by *Utah Code* Section 63-46a-6 (2001); and *Utah Administrative Code* Rule R15-2, and Sections R15-4-3, R15-4-5, R15-4-7, and R15-4-9.

The Changes in Proposed Rules Begin on the Following Page.

**Alcoholic Beverage Control,
Administration
R81-4D-14
Reporting Requirement**

NOTICE OF CHANGE IN PROPOSED RULE

DAR File No.: 27847
Filed: 07/01/2005, 14:35

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The changes to the proposed rule amendment are made pursuant to comments received from the public during the public comment period.

SUMMARY OF THE RULE OR CHANGE: Those who commented on the proposed amendment expressed concerns regarding several issues including what is required if events are scheduled after the report filing date, how the reports may be filed, how explicit the report must be in terms of event location, and issues of confidentiality once the reports are filed. The changes to this proposed rule address these questions and bring the rule into compliance with the Government Records Access and Management Act provisions of state law (Sections 63-2-304 and 63-2-308). (DAR NOTE: This change in proposed rule has been filed to make additional changes to a proposed amendment that was published in the May 15, 2005, issue of the Utah State Bulletin, on page 11. Underlining in the rule below indicates text that has been added since the publication of the proposed rule mentioned above; strike-out indicates text that has been deleted. You must view the change in proposed rule and the proposed amendment together to understand all of the changes that will be enforceable should the agency make this rule effective.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 32A-1-107

ANTICIPATED COST OR SAVINGS TO:

- ❖ **THE STATE BUDGET:** The changes to this proposed rule will not affect a cost or savings to the state budget since they are made to clarify some provisions of the rule and do not significantly alter the general requirements of the rule.
- ❖ **LOCAL GOVERNMENTS:** None--The changes to this proposed rule affect banquet establishments licensed by the Department of Alcoholic Beverage Control (DABC) and will not have a fiscal affect on local governments.
- ❖ **OTHER PERSONS:** None--The changes to this proposed rule simply clarify the requirements of the rule and have no additional fiscal impact on licensees.

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--The changes to this proposed rule simply clarify the requirements of the rule and have no additional fiscal impact on licensees.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The comments received by DABC were considered reasonable and the concerns expressed are being addressed in the changes being

submitted. These changes are made to clarify some of the rule's provisions and to guarantee confidentiality protection to licensees as they file their quarterly reports. Because of these changes to this rule, banquet licensees who file the required reports will know the information in their reports will not be shared with competitors and their fiscal interests will not be compromised. Kenneth F. Wynn, Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

ALCOHOLIC BEVERAGE CONTROL
ADMINISTRATION
1625 S 900 W
SALT LAKE CITY UT 84104-1630, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Sharon Mackay at the above address, by phone at 801-977-6800, by FAX at 801-977-6889, or by Internet E-mail at smackay@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: Kenneth F. Wynn, Director

**R81. Alcoholic Beverage Control, Administration.
R81-4D. On-Premise Banquet License.
R81-4D-14. Reporting Requirement.**

(1) Authority. This rule is pursuant to the commission's powers and duties under 32A-1-107 to act as a general policymaking body on the subject of alcoholic beverage control and to set policy by written rules that prescribe the conduct and management of any premises upon which alcoholic beverages may be sold, consumed, served, or stored, and pursuant to 32A-4-406(24).

(2) Purpose. This rule implements the requirement of 32A-4-406(24) that requires the commission to provide by rule procedures for on-premise banquet licensees to report scheduled banquet events to the department to allow random inspections of banquets by authorized representatives of the commission, the department, or by law enforcement officers to monitor compliance with the alcoholic beverage control laws.

(3) Application of the Rule.

(a) An on-premise banquet licensee shall file with the department at the beginning of each quarter a report containing advance notice of events or functions that have been scheduled as of the reporting date for that quarter to be held under a banquet contract as defined in R81-4D-1.

(b) The quarterly reports are due on or before January 1, April 1, July 1, and October 1 of each year and may be hand-delivered or submitted by mail or electronically.

(c) Each report shall include the name and specific location of each event.

(e)(d) The department shall make copies of the reports available to a commissioner, authorized representative of the department, and any law enforcement officer upon request to be

used for the purpose stated in Section (2).

~~(d)~~(e) The department shall retain a copy of each report until the end of each reporting quarter.

~~(e)~~(f) Because any report filed under this rule contains commercial information, the disclosure of which could reasonably be expected to result in unfair competitive injury to the licensee submitting the information, and the licensee submitting the information has a greater interest in prohibiting access than the public in obtaining access to the report:

(i) any report filed shall be deemed to include a claim of business confidentiality, and a request that the report be classified as protected pursuant to 63-2-304 and -308;

(ii) any report filed shall be classified by the department as protected pursuant to 63-2-304; and

(iii) any report filed shall be used by the department and law enforcement only for the purposes stated in this rule.

(g) Failure of an on-premise banquet licensee to timely file the quarterly reports ~~is grounds for~~ may result in disciplinary action pursuant to 32A-1-119, 32A-4-406, and R81-1-6 and -7.

KEY: alcoholic beverages

2005

32A-1-107

32A-4 Part 4



Commerce, Real Estate

R162-2-1

Exam Application

NOTICE OF CHANGE IN PROPOSED RULE

DAR File No.: 27951
Filed: 06/30/2005, 17:02

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The original proposed amendment published under DAR No. 27951 would erroneously delete Subsection R162-2-1(2.1.4.1)(b) from the current rule. Subsection R162-2-1(2.1.4.1)(b) does not conflict with Section 61-2-9 as it was first thought, and is still needed.

SUMMARY OF THE RULE OR CHANGE: Current Subsection R162-2-1(2.1.4.1)(b) concerning out-of-state applicants whose licenses in their home states were on inactive status at the time of application for a Utah license is still needed and is added back in. (DAR NOTE: This change in proposed rule has been filed to make additional changes to a proposed amendment that was published in the June 15, 2005, issue of the Utah State Bulletin, on page 15. Underlining in the rule below indicates text that has been added since the publication of the proposed rule mentioned above; strike-out indicates text that has been deleted. You must view the change in proposed rule and the proposed amendment together to understand all of the changes that will be enforceable should the agency make this rule effective.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 61-2-5.5(1)(a)(i)

ANTICIPATED COST OR SAVINGS TO:

- ❖ THE STATE BUDGET: No change over what was filed in the original rule amendment.
- ❖ LOCAL GOVERNMENTS: No change from what was filed in the original rule amendment.
- ❖ OTHER PERSONS: No change from what was filed in the original rule amendment.

COMPLIANCE COSTS FOR AFFECTED PERSONS: No change from what was filed in the original rule amendment.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule filing establishes the education requirements for licensees and requires the education to be completed prior to taking the examination. Other than the impact to license applicants who have no high school diploma, GED, or equivalent, no fiscal impact to businesses is anticipated as a result of this filing. Russell C. Skousen, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

COMMERCE
REAL ESTATE
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY UT 84111-2316, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Shelley Wismer at the above address, by phone at 801-530-6761, by FAX at 801-530-6749, or by Internet E-mail at swismer@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: Dexter Bell, Director

R162. Commerce, Real Estate.

R162-2. Exam and License Application Requirements.

R162-2-1. Qualifications for Licensure and Exam Application.

2.1.1 Minimum Age. All applicants shall be at least 18 years of age.

2.1.2 Formal Education Minimum. All applicants shall have at least a high school diploma, G.E.D., or equivalent as determined by the Commission.

2.1.3 Prelicensing Education. All applicants shall have completed any required prelicensing education before applying to sit for a licensing examination.

2.1.4 Exam application. All applicants who desire to sit for a licensing examination shall deliver an application to sit for the examination, together with the applicable examination fee, to the testing service designated by the Division. If the applicant fails to take the examination when scheduled, the fee will be forfeited.

2.1.4.1. Applicants previously licensed out-of-state.

(a) If an applicant is now and has been actively licensed for the preceding two years in another state which has substantially equivalent licensing requirements and is either a new resident or a non-resident of this state, the Division shall waive the national portion of the exam.

(b) If an applicant has been on an inactive status for any portion of the past two years he may be required to take both the national and Utah state portions of the exam.

KEY: real estate business

2005

Notice of Continuation June 12, 2002

61-2-5.5

Insurance, Administration

R590-146

Medicare Supplement Insurance Standards

NOTICE OF CHANGE IN PROPOSED RULE

DAR File No.: 27810
Filed: 06/27/2005, 15:31

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The changes being made to the rule were suggested during the hearing and comment period.

SUMMARY OF THE RULE OR CHANGE: Subsection R590-146-4(F) changed the definition of "credible coverage" to reference the code so there weren't have two different definitions. Subsection R590-146-7(B) removed the word "minimum" from the title. There were also technical corrections made and throughout the rule the word "agent" has been changed to "producer." Subsection R590-146-10(F)(1) removed the deemer clause. Subsection R590-146-10(F)(2) changed filing requirement to 30 days after the change rather than quarterly. Subsection R590-146-12(A) removed subsection (3) since it is also in Subsection R590-146-12(C)(1). Subsection R590-146-14(A)(2) and Subsection R590-146-15(C) clarifies that the insurer must also comply with Rule R590-85. Subsection R590-146-14(C)(1)(d) clarifies that the insurer must also comply with Rule R590-220. Section R590-146-24 added the the National Association of Insurance Commissioner's Disclosure Statements and Medicare Supplement Outlines. (DAR NOTE: This change in proposed rule has been filed to make additional changes to a proposed amendment that was published in the May 1, 2005, issue of the Utah State Bulletin, on page 19. Underlining in the rule below indicates text that has been added since the publication of the proposed rule mentioned above; strike-out indicates text that has been deleted. You must view the change in proposed rule and the proposed amendment together to understand all of the changes that will be enforceable should the agency make this rule effective.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 31A-22-620

THIS RULE OR CHANGE INCORPORATES BY REFERENCE THE FOLLOWING MATERIAL: Medicare Supplement Refund Calculation Form; Reporting Form for the Calculation of Benchmark Ratio Since Inception For Group Policies; Form for Reporting Medicare Supplement Policies; Disclosure Statements; and Outline of Medicare Supplement Coverage

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: The changes to this rule will have no fiscal impact on the department. There will be no need to increase or reduce the staff nor will the budget or revenues be affected.

❖ LOCAL GOVERNMENTS: The changes to this rule will not affect local government since the rule only applies to the relationship between health insurers and the department and their insureds.

❖ OTHER PERSONS: Health insurance companies are already following the new provisions of this rule. As a result insurers and consumers should not experience any fiscal impact from these changes.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Health insurance companies are already following the new provisions of this rule. As a result insurers and consumers should not experience any fiscal impact from these changes.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no impact on Utah businesses as a result of the changes being made to this rule. D. Kent Michie, Commissioner

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

INSURANCE
ADMINISTRATION
Room 3110 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY UT 84114-1201, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Jilene Whitby at the above address, by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at jwhitby@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 08/16/2005

AUTHORIZED BY: Jilene Whitby, Information Specialist

R590. Insurance, Administration.**R590-146. Medicare Supplement Insurance Standards.****R590-146-1. Authority.**

This rule is issued pursuant to the authority vested in the commissioner under Subsection 31A-22-620(3)(c), (d) and (e) requiring the commissioner to adopt rules to establish minimum standards for [F]individual and [G]group Medicare [S]supplement [F]insurance.

R590-146-2. Purpose.

The purpose of this rule is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare; and to establish rating and reporting requirements.

R590-146-3. Applicability and Scope.

A. Except as otherwise specifically provided in Sections 7, 13, 14, 17 and 22, this rule shall apply to:

(1) all Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this rule; and

(2) all certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.

B. This rule shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination, of the labor organizations.

R590-146-4. Definitions.

For purposes of this rule:

A. "Applicant" means:

(1) in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

(2) in the case of a group Medicare supplement policy, the proposed certificateholder.

B. "Bankruptcy" means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

C. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

D. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

E. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

F. [F] "Creditable coverage" has the same meaning as provided in Section 31A-1-301 [federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

— (a) a group health plan;

— (b) health insurance coverage;

— (c) Part A or Part B of Title XVIII of the Social Security Act, Medicare;

— (d) Title XIX of the Social Security Act, Medicaid, other than coverage consisting solely of benefits under section 1928;

— (e) Chapter 55 of Title 10 United States Code, CHAMPUS;

— (f) a medical care program of the Indian Health Service or of a tribal organization;

— (g) a State health benefits risk pool;

— (h) a health plan offered under chapter 89 of Title 5 United States Code, Federal Employees Health Benefits Program;

— (i) a public health plan as defined in federal regulation; and

— (j) a health benefit plan under Section 5(e) of the Peace Corps Act, 22 United States Code 2504(e).

(2) "Creditable coverage" shall not include one or more, or any combination of, the following:

— (a) coverage only for accident or disability income insurance, or any combination thereof;

— (b) coverage issued as a supplement to liability insurance;

— (c) liability insurance, including general liability insurance and automobile liability insurance;

— (d) workers' compensation or similar insurance;

— (e) automobile medical payment insurance;

— (f) credit only insurance;

— (g) coverage for on-site medical clinics; and

— (h) other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

— (a) limited scope dental or vision benefits;

— (b) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

— (c) such other similar, limited benefits as are specified in federal regulations.

(4) "Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

— (a) coverage only for a specified disease or illness; and

— (b) hospital indemnity or other fixed indemnity insurance.

(5) "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

— (a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

— (b) coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and

— (c) similar supplemental coverage provided to coverage under a group health plan.]

G. "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002, Employee Retirement Income Security Act.

H. "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

I. "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

J. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

K. "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in U.S.C. 1395w-28(b)(1), and includes:

(1) coordinated care plans which provide health care services, including but not limited to health maintenance organization plans, with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans;

(2) medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and

(3) Medicare Advantage private fee-for-service plans.

L. "Medicare supplement policy" means a group or individual policy of disability insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act, 42 U.S.C. Section 1395 et seq., or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan, HCPP, that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.

M. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

N. "Secretary" means the Secretary of the United States Department of Health and Human Services.

R590-146-5. Policy Definitions and Terms.

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms, which conform to the requirements of this section.

A. "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words, which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

B. "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

C. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

D. "Health care expenses" means, for purposes of Section 14, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

E. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

F. "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

G. "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

H. "Physician" shall not be defined more restrictively than as defined in the Medicare program.

I. "Sickness" shall not be defined to be more restrictive than the following:

"Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."

The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

R590-146-6. Policy Provisions.

A. Except for permitted preexisting condition clauses as described in Subsections 7A(1) and 8A(1) of this rule, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

B. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No Medicare supplement policy or certificate in force in the state shall contain benefits, which duplicate benefits provided by Medicare.

D. (1) Subject to Subsections 7 (A)(4),(5) and (7) and 8(A)(4) and (5), a Medicare supplement policy with benefits for outpatient drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

(2) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005. (3) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

(a) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan, and;

(b) Premiums are adjusted to reflect the elimination of outpatient prescription coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

R590-146-7. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to July 30, 1992.

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(4) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

(a) provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(b) be canceled or non[-]renewed by the issuer solely on the grounds of deterioration of health.

(5)(a) Except as authorized by the commissioner of this state, an issuer shall neither cancel nor non[-]renew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(b) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Subsection (5)(d), the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:

(i) an individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(ii) an individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Subsection 8B of this rule.

(c) If membership in a group is terminated, the issuer shall:

(i) offer the certificateholder the conversion opportunities described in Subsection (b); or

(ii) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group.

(d) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

B. ~~Minimum~~ Benefit Standards. Every issuer shall include the following benefits:

(1) ~~[C]~~ coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) ~~[C]~~ coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

(3) ~~[C]~~ coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(4) ~~[F]~~ upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) ~~[C]~~ coverage under Medicare Part A for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations or already paid for under Part B;

(6) ~~[C]~~ coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible, \$100; and

(7) ~~[E]~~ effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

R590-146-8. Benefit Standards for Policies or Certificates Issued or Delivered on or After July 30, 1992.

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 30, 1992. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable.

(a) The issuer shall not cancel or non[-]renew the policy solely on the ground of health status of the individual.

(b) The issuer shall not cancel or non[-]renew the policy for any reason other than nonpayment of premium or material misrepresentation.

(c) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Subsection 8A(5)(e), the issuer shall offer certificateholders an individual Medicare supplement policy which, at the option of the certificateholder:

(i) provides for continuation of the benefits contained in the group policy; or

(ii) provides for benefits that otherwise meet the requirements of this subsection.

(d) [i]f an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(i) offer the certificateholder the conversion opportunity described in Subsection 8A(5)(c); or

(ii) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(e) [i]f a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(f) [i]f a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this ~~Subsection~~ subsection.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7)(a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period, not to exceed 24 months, in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance.

(b) If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated, effective as of the date of termination of entitlement, ~~[as of the termination of entitlement]~~ if the policyholder or certificateholder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period ~~[effective as of the date of termination of entitlement]~~.

(c) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended, for the period provided by federal regulation, at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan, as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated, effective as of the date of loss of coverage, if the policyholder provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(d) Reinstatement of coverages:

(i) shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(iii) shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

B. Standards for Basic, Core, Benefits Common to All Benefit Plans ~~[A-F]~~.

Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system, PPS_{rate} or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations.

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services under a prospective payment system, the co[-]payment amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 9 of this rule.

(1) Medicare Part A Deductible: Coverage for ~~[all of the]~~the entire Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A.

(3) Medicare Part B Deductible: Coverage for ~~[all of the]~~the entire Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) 80% of the Medicare Part B Excess Charges: Coverage for 80% of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(5) 100% of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Basic Outpatient Prescription Drug Benefit: Coverage for 50% of outpatient prescription drug charges, after a \$250 calendar year deductible, to a maximum of \$1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(7) Extended Outpatient Prescription Drug Benefit: Coverage for 50% of outpatient prescription drug charges, after a \$250 calendar year deductible to a maximum of \$3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(8) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) Preventive Medical Care Benefit~~[-]~~

(a) Coverage for the following preventive health services not covered by Medicare:

~~(i)~~ (A) an annual clinical preventive medical history and physical examination that may include tests and services from Subsection (b) and patient education to address preventive health care measures~~[-]~~; and

~~(ii)~~ (P) preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

~~(e)~~(b) Reimbursement shall be for the actual charges up to 100% of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology, AMA CPT, codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(a) For purposes of this benefit, the following definitions shall apply:

(i) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(iii) "Home" shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

(b) Coverage Requirements and Limitations

(i) At-home recovery services provided shall be primarily services, which assist in activities of daily living.

(ii) The insured's attending physician shall certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to:

(I) no more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of \$40 per visit;

(III) \$1,600 per calendar year;

(IV) seven visits in any one week;

(V) care furnished on a visiting basis in the insured's home;

(VI) services provided by a care provider as defined in this section;

(VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded; and

(VIII) at-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

(c) Coverage is excluded for:

(i) home care visits paid for by Medicare or other government programs; and

(ii) care provided by family members, unpaid volunteers or providers who are not care providers.

D. Standards for Plans K and L.

(1) Standardized Medicare supplement benefit plan "K" shall consist of the following:

(a) [C]coverage of 100 % of the part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(b) [C]coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(c) [F]upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system, PPS, rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) [M]medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subsection (j);

(e) [S]skilled Nursing Facility Care: Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subsection (j);

(f) [H]hospice Care: Coverage for 50% of the cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subsection (j);

(g) [C]coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subsection (j);

(h) [E]except for coverage provided in Subsection (i) below, coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subsection (j) below;

(i) [C]coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) [C]coverage of 100% of all cost sharing under Medicare Part A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Part A and B of \$4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(2) Standardized Medicare supplement benefit plan "L" shall consist of the following:

(a) The benefits described in Subsections 146-8(D)(1)(a), (b), (c) and (i);

(b) The benefits described in Subsections 146-8 (D)(1) (d), (e), (f), (g) and (h), but substituting 75% for 50%; and

(c) The benefit described in Subsection 146-8 (D)(1)(j), but substituting \$2000 for \$4000.

R590-146-9. Standard Medicare Supplement Benefit Plans.

A. An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic core benefits, as defined in Subsection 8B of this rule.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section may be offered for sale in this state, except as may be permitted in [Subsection 9(G) and in]Section 10 of this rule.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this section and conform to the definitions in Section 4 of this rule. Each benefit shall be structured in accordance with the format provided in Subsections 8B and 8C, or 8D and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in Subsection C, other designations to the extent permitted by law. Make-up of benefit plans:

(1) Standardized Medicare supplement benefit plan "A" shall be limited to the basic, core, benefits common to all benefit plans, as defined in Subsection 8B of this rule.

(2) Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible as defined in Subsection 8C(1).

(3) Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in Subsections 8C(1), (2), (3) and (8) respectively.

(4) Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefit, as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in an foreign country and the at-home recovery benefit as defined in Subsections 8C(1), (2), (8) and (10) respectively.

(5) Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in Subsections 8C(1), (2), (8) and (9) respectively.

(6) Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Subsections 8C(1), (2), (3), (5) and (8) respectively.

(7) Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Subsections 8C(1), (2), (3), (5) and (8) respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be \$1500 for 1998 and 1999,

and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

(8) Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, 80% of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in Subsections 8C(1), (2), (4), (8) and (10) respectively.

(9) Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in Subsections 8C(1), (2), (6) and (8) respectively. The prescription drug benefit shall not be included in a ~~new~~ Medicare supplement policy sold after December 31, 2005.

(10) Standardized Medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in Subsections 8C(1), (2), (5), (6), (8) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(11) Standardized Medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100% of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in Subsections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(12) Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100% of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in Subsections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be \$1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(E) ~~Make up of two~~ Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003~~[-MMA-]~~.

(1) Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in Section 8D(1).

(2) Standardized Medicare supplement benefit plan "L" shall consist of only those benefits described in Section 8D(2).

§590-146-10. Medicare Select Policies and Certificates.

A. ~~(4)~~ This section shall apply to Medicare Select policies and certificates, as defined in this section.

~~(2)~~ No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

B. For the purposes of this section:

(1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(3) "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(4) "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(5) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

(6) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

C. The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act, OBRA, of 1990 if the commissioner finds that the issuer has satisfied all of the requirements of this rule.

D. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until ~~the commissioner has approved its plan of operation~~ its plan of operation has been approved by the commissioner.

E. A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(1) ~~E~~vidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(a) ~~S~~ervices can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community~~[-]~~;

(b) ~~F~~the number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) to deliver adequately all services that are subject to a restricted network provision; or

(ii) to make appropriate referrals[-]; and

(c) ~~[F]~~there are written agreements with network providers describing specific responsibilities[-];

(d) ~~[E]~~emergency care is available 24 hours per day and seven days per week[-];

(e) ~~[F]~~in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This subsection shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate[-];

(2) ~~[A]~~a statement or map providing a clear description of the service area[-];

(3) ~~[A]~~a description of the grievance procedure to be utilized[-];

(4) ~~[A]~~a description of the quality assurance program, including:

(a) the formal organizational structure;

(b) the written criteria for selection, retention and removal of network providers; and

(c) the procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted[-];

(5) ~~[A]~~a list and description, by specialty, of the network providers[-];

(6) ~~[C]~~copies of the written information proposed to be used by the issuer to comply with Subsection I[-];

(7) Any other information requested by the commissioner.

F.(1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing the changes. ~~Changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.~~

(2) Any ~~updated~~ changes to the list of network providers shall be filed with the commissioner ~~at least quarterly~~ within 30 days of the change. The submission must include all network providers and clearly identify the new and discontinued providers.

G. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

(1) the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

(2) it is not reasonable to obtain services through a network provider.

H. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

I. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) ~~[A]~~an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(a) other Medicare supplement policies or certificates offered by the issuer; and

(b) other Medicare Select policies or certificates[-];

(2) ~~[A]~~a description, including address, phone number and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals and other providers[-];

(3) ~~[A]~~a description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L[-];

(4) ~~[A]~~a description of coverage for emergency and urgently needed care and other out-of-service area coverage[-];

(5) ~~[A]~~a description of limitations on referrals to restricted network providers and to other providers[-];

(6) ~~[A]~~a description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer[-]; and

(7) ~~[A]~~a description of the Medicare Select issuer's quality assurance program and grievance procedure.

J. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection I of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

K. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than ~~each~~ March 31st of each calendar year to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

L. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

M.(1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

N. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

O. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

R590-146-11. Open Enrollment.

A. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this section without regard to age.

B.-(1) If an applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

C. Except as provided in Subsection B and Sections 12 and 23, Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

R590-146-12. Guaranteed Issue for Eligible Persons.

A. Guaranteed Issue.

(1) Eligible persons are those individuals described in subsection B who seek to enroll under the policy during the period specified in

Subsection C, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection E that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.[-]

~~--- (3) In case of the individual described in Subsection A, the guaranteed issue period begins on the later of:~~

~~--- (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits, or if a notice is not received, notice that a claim has been denied because of such a termination or cessation; or~~

~~--- (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three days thereafter.]~~

B. Eligible Persons.

An eligible person is an individual described in any of the following subsections:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual[;].

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a program of All-Inclusive Care for the Elderly, PACE, provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(a) the certification of the organization, or plan under this part, has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

(b) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuance of such plan;

(c) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in [s]Section 1851(g)(3)(B) of the federal Social Security Act, where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under [s]Section 1856, or the plan is terminated for all individuals within a residence area;

(d) the individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) the organization, or [agent]producer or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(e) the individual meets such other exceptional conditions as the Secretary may provide."

(3)-(a) The individual is enrolled with:

(i) an eligible organization under a contract under Section 1876 of the Social Security Act, Medicare cost;

(ii) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(iii) an organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act, health care prepayment plan; or

(iv) an organization under a Medicare Select policy; and

(b) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage in Section 12B(2).

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(a)(i) of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(ii) of other involuntary termination of coverage or enrollment under the policy;

(b) the issuer of the policy substantially violated a material provision of the policy; or

(c) the issuer, or a[n] ~~agent~~ producer or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5)(a) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act, Medicare cost, any similar organization operating under demonstration project authority, any PACE program under Section 1894 of the Social Security Act or a Medicare Select policy; and

(b) The subsequent enrollment under Subsection (a) is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment, during which the enrollee is permitted to terminate such subsequent enrollment under [s]Section 1851(e) of the federal Social Security Act; or

(6) The individual, upon first becoming eligible for benefits under part A of Medicare, enrolls in a Medicare Advantage plan under part C of Medicare, or in a PACE program under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Subsection E(4).

(8) The individual is enrolled under medical assistance under Title XIX of the Social Security Act, Medicaid, and is involuntarily terminated outside of requirements of Subsection 8(A)(7)(a) and (b).

C. Guaranteed Issue Time Periods.

(1) In the case of an individual described in Subsection B(1), the guaranteed issue period begins on the later of:

(i) the date the individual receives a notice of termination or cessation of all supplemental health benefits or, if a notice is not received, noticed that a claim has been denied because of a termination or cessation; or

(ii) the date that the applicable coverage terminates or ceases; and ends sixty-three days thereafter;

(2) In case of an individual described in Subsections B(2), B(3), B(5) or B(6), whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three days after the date applicable coverage is terminated[;].

(3) In the case of an individual described in Subsection B(4)(a), the guaranteed issue period begins on the earlier of:

(i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any[;]; and

(ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three days after the date the coverage is terminated[;].

(4) In case of an individual described in Subsections B(2), B(4)(b), B(4)(c), B(5) or B(6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty days before the effective date of the disenrollment and ends on the day that is sixty-three days after the effective date[;].

(5) In the case of an individual described in Subsection B(7), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day period immediately preceding the initial Part D enrollment period ends on the date that is sixty-three days after the effective date of the individual's coverage under Medicare Part D[~~and~~].

(6) In case of an individual described in Subsection B but not described in the preceding provisions of this [S]subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on that date that is sixty-three days after the effective date.

D. Extended Medigap Access for Interrupted [~~Final~~] Trial Periods

(1) In the case of an individual described in Subsection B(5), or deemed to be so described, pursuant to this [S]subsection, whose enrollment with a plan or in a program described in Subsection B(6) is involuntarily terminated within the first twelve months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(5);

(2) In the case of an individual described in Subsection B(6), or deemed to be so described, pursuant to this Subsection, whose enrollment with a plan or in a program described in Subsection B(6) is involuntarily terminated within the first twelve months of enrollment, and who, without an intervening enrollments, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(6)[~~and~~].

(3) For the purposes of Subsections B(5) and B(6), no enrollment of an individual with an organization or provider described in Subsection B(5)(a), or with a plan or in a program described in Subsection B(6), may be deemed to be an initial enrollment under this [~~Subsection~~]subsection after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

E. Products to Which Eligible Persons are Entitled

The Medicare supplement policy to which eligible persons are entitled under:

(1) Subsections 12B(1), (2), (3), [~~and~~] (4), and (8) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F, including F with a high deductible, K or L offered by any issuer.

(2)(a) Subject to Subsection (b), Subsection 12B(5) is the same Medicare supplement policy in which the individual was most recently

previously enrolled, if available from the same issuer, or, if not so available, a policy described in Subsection (1)[~~5~~].

(b) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with a outpatient drug benefit, a Medicare supplement policy described in this [~~S~~]subsection is:

(i) [~~F~~]the policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(ii) [~~A~~]at the election of the policyholder, an A, B, C, F, including F with a high deductible, K or L policy that is offered by any issuer;

(3) Subsection 12B(6) shall include any Medicare supplement policy offered by any issuer.

(4) ~~Subsection~~[~~Section~~] 12B(7) is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F[-], including F with a high deductible, K, or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

[~~D~~]E. Notification provisions.

(1) At the time of an event described in Subsection B of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection A. Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in Subsection B of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection 12A. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

R590-146-13. Standards for Claims Payment.

A. An issuer shall comply with [~~s~~]Section 1882(c)(3) of the Social Security Act, as enacted by [~~s~~]Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987, OBRA, 1987, Pub. L. No. 100-203, by:

(1) accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) notifying the participating physician or supplier and the beneficiary of the payment determination;

(3) paying the participating physician or supplier directly;

(4) furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(5) paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in Subsection A above shall be certified on the Medicare supplement insurance experience reporting form.

R590-146-14. Loss Ratio Standards and Refund or Credit of Premium.

A. Loss Ratio Standards.

(1)(a) A Medicare [~~S~~]supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form:

(i) at least 75% of the aggregate amount of premiums earned in the case of group policies; or

(ii) at least 65% of the aggregate amount of premiums earned in the case of individual policies;

(b) The loss ratio shall be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(i) [~~H~~]home office and overhead costs;

(ii) [~~A~~]advertising costs;

(iii) [~~C~~]commissions and other acquisition costs;

(iv) [~~F~~]taxes;

(v) [~~C~~]capital costs;

(vi) [~~A~~]administration costs; and

(vii) [~~C~~]claims processing costs.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards, and comply with the requirements of R590-85.

(3) For policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet:

(a) the originally filed anticipated loss ratio when combined with the actual experience since inception;

(b) the appropriate loss ratio requirement from Subsections A(1)(a)(i) and (ii) when combined with actual experience beginning with the effective date of October 31, 1994 as set forth in Bulletin 94-8; and

(c) the appropriate loss ratio requirement from Subsections A(1)(a)(i) and (ii) over the entire future period for which the rates are computed to provide coverage.

B. Refund or Credit Calculation.

(1) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception[~~]~~ ratio 1, exceeds the adjusted experience ratio since inception[~~]~~ ratio 3, then a refund or credit calculation~~]~~ is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For

purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) For the purposes of this section, policies or certificates issued prior to July 30, 1992, the issuer shall make the refund or credit calculation separately for all individual policies, including all group policies subject to an individual loss ratio standard when issued, combined and all other group policies combined for experience after the effective date of this rule. The first report shall be due by May 31[; 1998] each year.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual Filing of Premium Rates.

An issuer of Medicare supplement policies and certificates issued before or after the effective date of July 30, 1992 in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio, which is greater than or equal to the applicable percentage, shall be demonstrated for policies or certificates in force less than three years.

(1)(a) As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state [:(1)(a) A] appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.

(b) As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state [A] an issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(c) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

(d) The Annual Filing of Premium Rates must be filed in compliance with R590-220-11.

(e) The Annual Filing of Premium Rates shall be filed no later than May 31 each year.

(2) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public Hearings.

The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of July 30, 1996 if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the commissioner.

R590-146-15. Filing of Policies, Certificates, and Premium Rates.

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed for use in accordance with filing requirements and procedures prescribed by the commissioner.

B. An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

C. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed for acceptance in accordance with the filing requirements and procedures prescribed by the commissioner, and Rule R590-85.

D.(1) Except as provided in Subsection (2) of this subsection, an issuer shall not file more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

- (a) the inclusion of new or innovative benefits;
- (b) the addition of either direct response or [agent]producer marketing methods;
- (c) the addition of either guaranteed issue or underwritten coverage;
- (d) the offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

E.(1) Except as provided in Subsection (1)(a), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this rule that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days prior to discontinuing the availability of the

form of the policy or certificate. After receipt of the notice by the commissioner, the issuer may no longer offer for sale the policy form or certificate form in this state.

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to Subsection (a) shall not file a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this section.

(3) A change in the rating structure or methodology shall be considered a discontinuance under Subsection (1) unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential, which is in the public interest.

F.(1) Except as provided in Subsection (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Rule R590-146-14.

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

R590-146-16. Permitted Compensation Arrangements.

A. An issuer or other entity may provide commission or other compensation to a[n] ~~agent~~ producer or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200% of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent renewal years shall be the same as that provided in the second year or period and shall be provided for no fewer than five renewal years.

C. No issuer or other entity may provide compensation to its ~~agents~~ producers or other producers and no ~~agent or~~ producer may receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

D. For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

R590-146-17. Required Disclosure Provisions.

A. General Rules.

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the

right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate ~~[S]~~ subsection of the policy and be labeled as "Preexisting Condition Limitations."

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6)(a) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the ~~[CMS]~~ Centers for Medicare and Medicaid Services (CMS) ~~and~~ in a type size no smaller than 12 point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this rule. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

(b) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice Requirements.

(1) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. The notice shall:

(a) include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

(b) inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) The notices shall not contain or be accompanied by any solicitation.

C. MMA Notice Requirements.

Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

D. Outline of Coverage Requirements for Medicare Supplement Policies.

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant ~~[-and]~~.

(2) ~~[i]~~ If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12 point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(3) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All plans A-L shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) The Outline of Medicare Supplement Coverage, from the National Association of Insurance Commissioners, dated 1998, as incorporated by reference herein, is available for public inspection at the Insurance Department.

E. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

(1) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act, 42 U.S.C. 1395 et seq., disability income policy; or other policy identified in Subsection 3B of this rule, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than 12-point type and shall contain the following language:

"THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CONTRACT). If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Subsection D(1) shall disclose, using the applicable statement in Appendix C, the extent

to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

R590-146-18. Requirements for Application Forms and Replacement Coverage.

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and ~~agent~~ producer containing such questions and statements may be used.

TABLE I

(Statements)
(Boldface Type)

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy or, if that is no longer available, a substantially equivalent policy, will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy or, if that is no longer available, a substantially equivalent policy, will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Questions
(Boldface Type)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy,

you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with the application. PLEASE ANSWER ~~[A-]~~ [ALL] QUESTIONS.

(Please mark Yes or No below with an "X")

To the best of your knowledge,

- (1)(a) Did you turn age 65 in the last 6 months?
(b) Did you enroll in Medicare Part B in the last 6 months?
(c) If yes, what is the effective date?
(2) Are you covered for medical assistance through the state Medicaid program?

(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.)

- (a) Will Medicaid pay your premiums for this Medicare supplement policy?

- (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

(3)(a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days, for example, a Medicare Advantage plan, or a Medicare HMO or PPO, fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START / / END / /

- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

- (c) Was this your first time in this type of Medicare plan?

- (d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

- (4)(a) Do you have another Medicare supplement policy in force?

- (b) If so, with what company, and what plan do you have (optional for Direct Mailers)?

- (c) If so, do you intend to replace your current Medicare supplement policy with this policy?

- (5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

- (a) If so, with what company and what kind of policy?

- (b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.

START / / END / /

B. [Agents]Producers shall list any other health insurance policies they have sold to the applicant.

- (1) List policies sold which are still in force.
(2) List policies sold in the past five years, [that]which are no longer in force.

C. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its [agent]producer, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a

notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the [agent]producer, except where the coverage is sold without a[n] [agent]producer, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

E. The notice required by Subsection D above for an issuer shall be provided in substantially the following form in no less than [twelve] 12-point type:

TABLE II
NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE

(Boldface Type)
(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.
(Boldface Type)

According to (your application) (information you have furnished), you intend to terminate existing Medicare supplement insurance or Medicare Advantage and replace it with a policy to be issued by (Company Name) Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare supplement coverage.

You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.
STATEMENT TO APPLICANT BY ISSUER, [AGENT]PRODUCER (BROKER OR OTHER REPRESENTATIVE):

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits.
.... No change in benefits, but lower premiums.
.... Fewer benefits and lower premiums.
.... My plan has outpatient prescription drug coverage and I am enrolling in Part D.
.... Disenrollment from a Medicare Advantage plan.
Please explain reason for disenrollment. (optional only for Direct Mailer.)
.... Other. (please specify)

1. Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage)

for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. (If the policy or certificate is guaranteed issue, this [§] subsection need not appear.)

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

.....
(Signature of [Agent] Producer, Broker or Other Representative)

(Typed Name and Address of Issuer, [Agent] Producer or Broker)

.....
(Applicant's Signature)

.....
(Date)

Signature not required for direct response sales.

F. Subsections 1 and 2 of the replacement notice, applicable to preexisting conditions, may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

R590-146-19. Filing Requirements for Advertising.

An issuer shall, upon specific request from the commissioner, file for use a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio, electronic, or television medium.

R590-146-20. Standards for Marketing.

- A. An issuer, directly or through its producers, shall:
 - (1) establish marketing procedures to assure that any comparison of policies by its [~~agents or other~~] producers will be fair and accurate;
 - (2) establish marketing procedures to assure excessive insurance is not sold or issued.
 - (3) display prominently by type, stamp or other appropriate means, on the first page of the policy the following:
 - "Notice to buyer: This policy may not cover all of your medical expenses"
 - (4) inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance; and
 - (5) establish auditable procedures for verifying compliance with this Subsection A.

B. In addition to the practices prohibited in Section 31A-23-302, the following acts and practices are prohibited:

- (1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer.
- (2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance

through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance [agent] producer or insurance company.

C. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this rule.

R590-146-21. Appropriateness of Recommended Purchase and Excessive Insurance.

A. In recommending the purchase or replacement of any Medicare supplement policy or certificate a[n] [agent] producer shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

C. An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

R590-146-22. Reporting of Multiple Policies.

A. On or before May 31 of each year, an issuer shall report the following information on the applicable reporting form contained in Appendix B for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

- (1) policy and certificate number; and
- (2) date of issuance.

B. The items set forth above shall be grouped by individual policyholder.

R590-146-23. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates.

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

R590-146-24. Documents Incorporated by Reference.

The following filing documents are hereby incorporated by reference from the NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, September 2004:

- (1) "~~Appendix A: Reporting Form for Calculation of Loss Ratios~~ MEDICARE SUPPLEMENT REFUND CALCULATION FORM";

(2) "~~Appendix B: Form for Reporting Duplicate Policies~~REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES;" ~~and~~

(3) "~~Appendix C: Disclosure Statements~~"REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES;" ~~and~~

(4) "FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES;"

(5) "DISCLOSURE STATEMENTS;" and

(6) "OUTLINE OF MEDICARE SUPPLEMENT COVERAGE."

R590-146-25. Enforcement Date.

The commissioner will begin enforcing the ~~new~~ provisions of this rule January 1, 2006.

R590-146-26. Separability.

If any provision of this rule or the application to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected.

KEY: insurance

2005

Notice of Continuation April 23, 2002

31A-22-620



End of the Notices of Changes in Proposed Rules Section

NOTICES OF 120-DAY (EMERGENCY) RULES

An agency may file a 120-DAY (EMERGENCY) RULE when it finds that the regular rulemaking procedures would:

- (a) cause an imminent peril to the public health, safety, or welfare;
- (b) cause an imminent budget reduction because of budget restraints or federal requirements; or
- (c) place the agency in violation of federal or state law (*Utah Code* Subsection 63-46a-7(1) (2001)).

As with a PROPOSED RULE, a 120-DAY RULE is preceded by a RULE ANALYSIS. This analysis provides summary information about the 120-DAY RULE including the name of a contact person, justification for filing a 120-DAY RULE, anticipated cost impact of the rule, and legal cross-references. A row of dots in the text (· · · · ·) indicates that unaffected text was removed to conserve space.

A 120-DAY RULE is effective at the moment the Division of Administrative Rules receives the filing, or on a later date designated by the agency. A 120-DAY RULE is effective for 120 days or until it is superseded by a permanent rule.

Because 120-DAY RULES are effective immediately, the law does not require a public comment period. However, when an agency files a 120-DAY RULE, it usually files a PROPOSED RULE at the same time, to make the requirements permanent. Comment may be made on the proposed rule. Emergency or 120-DAY RULES are governed by *Utah Code* Section 63-46a-7 (2001); and *Utah Administrative Code* Section R15-4-8.

Human Services, Services for People with Disabilities **R539-7** Home Based Services

NOTICE OF 120-DAY (EMERGENCY) RULE

DAR FILE NO.: 28037
FILED: 06/20/2005, 11:13

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The change is proposed after a comprehensive revision and consolidation of the Division's rules.

SUMMARY OF THE RULE OR CHANGE: The changes involve repealing the current rule and placing these service descriptions in the Provider's service contracts with the Division. This rule is repealed in its entirety.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 62A-5-102 and 62A-5-103

ANTICIPATED COST OR SAVINGS TO:

- ❖ THE STATE BUDGET: None--This revision does not alter the basic operations or functions of the Division and, therefore, does not result in either cost or savings to the state. Repealing the rule will make the Division eligible for a new grant award of \$80,000,000.
- ❖ LOCAL GOVERNMENTS: None--Local government funding is not used. Therefore, there is no cost to local governments.
- ❖ OTHER PERSONS: None--This revision does not alter the basic operations or functions of the Division, and therefore, does not result in either cost or savings to other persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--This revision does not alter the basic operations and functions of the Division. Provider requirements now appear in their current service contracts. This does not result in either cost or savings to Providers or other affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: None--This revision does not alter the basic operations or functions of the Division. Provider requirements now appear in their current service contracts. This does not change the fiscal impact on service providers.

EMERGENCY RULE REASON AND JUSTIFICATION: REGULAR RULEMAKING PROCEDURES WOULD cause an imminent budget reduction because of budget restraints or federal requirements. place the agency in violation of federal or state law.

This rule is in conflict with federal requirements for Medicaid waiver grants. The federal reviewers have indicated that the current rule could adversely affect awarding an \$80,000,000 grant to the Division.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HUMAN SERVICES
SERVICES FOR PEOPLE WITH DISABILITIES
Room 411
120 N 200 W
SALT LAKE CITY UT 84103-1500, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Steven Bradford at the above address, by phone at 801-538-4197, by FAX at 801-538-4279, or by Internet E-mail at sbradford@utah.gov

THIS RULE IS EFFECTIVE ON: 06/20/2005

AUTHORIZED BY: George Kelner, Director

R539. Human Services, Services for People with Disabilities.

[R539-7. Home Based Services.

R539-7-1. Family Training and Assistance.

A. Policy.

Family Training and Assistance provides direct supports/services to families of people with disabilities so that the family can live as much like other families as possible, and enhance their ability to meet the many needs of their family member with a disability. The supports/services that a family receives shall be determined by the individual and family, based on their culture, values, preferences, and specific needs any given time.

B. Procedures.

1. Family Training and Assistance can involve any number or types of supports/services. These supports/services may address not only the needs of the person with a disability, but other family members as well. The main goals of Family Training and Assistance supports/services are:

a. To keep families together until the person with a disability chooses to live independently.

b. To allow the family to participate fully in the community.

c. To make a positive difference in the life of a person with a disability as well as the lives of all family members.

d. To minimize the need and cost of out of home placement.

2. Procedures may vary among Division regional offices, but will remain consistent with:

a. The region staff will determine the individual's eligibility according to R539-1-1, Eligibility for Services, and a region case manager will complete an assessment of supports/services needed by the individual and the family.

b. If the family has chosen:

(1) a provider agency, the case manager will ensure that the agency has a contract and is certified according to R539-6-7, Licensing and Certification, and R539-6-4, Training Requirements for Family Support and Respite Care Providers.

(2) a parent choice provider, the case manager will ensure that the form 945, Purchase of Individual Family Support Agreement, is signed and that any requested screening has been completed and that a provider file has been completed on each parent choice provider according to R539-6-7, Licensing and Certification.

R539-7-2. Respite Services.

A. Policy.

The Division of Services for People with Disabilities will contract to provide respite services for individuals with disabilities who are living in their family home, in Professional Parent homes, or are eligible individuals living in a foster care setting. The purpose of respite is to provide intermittent, time limited care to eligible individuals to enable parents and primary caretakers relief from the demands of parenting and living with a person with disabilities.

B. Procedures.

1. Respite care services should offer the least possible departure from the normal patterns of living, while still being effective in meeting the person's needs. Agency respite providers shall comply with R539-6-4, Training Requirements for Family Support and Respite Care Providers, and R539-6-7, Licensing and Certification. Respite services

may be provided at an hourly or daily rate, and respite may be provided in home or out of home.

a. The hourly rate is used when respite is provided up to no more than six hours/day.

b. The daily rate is used when respite is provided over six hours/day.

c. In Home Respite Care services are provided in the home of the individual with a disability. Family members may or may not be at home during this time. Respite care providers are specially trained and skilled persons who come into a family's home to care for a family member with disabilities. The services provided shall depend entirely on the needs of the families and family members involved.

d. Out of Home Respite Care services are provided in the private home of the respite provider. In rare situations and upon approval of the Emergency Services Management Committee and the region office, care may be provided in a nursing facility or specialized facility designed to provide respite care.

2. The Provider will coordinate the delivery of respite services to be provided with the region case manager, family member or primary caretaker, and person with a disability.

3. The Provider will document and report to the region case manager the individual's response to the respite placement and will coordinate with any applicable Individual Family Support Plan outcomes.

4. The Provider will maintain documentation of injuries and accidents.

5. No more than two individuals with disabilities will be served by any respite provider at any one time, unless the region director has reviewed the Individual's Family Support Plan and has approved the provider to serve additional persons; however, the number of individuals with disabilities served by a respite provider at any one time shall never exceed four individuals.

R539-7-3. Educational Services.

A. Policy.

Educational services provide opportunities for Division eligible adults to obtain education instruction, individual tutoring, and the opportunity to participate in generic educational classes or seminars that will enhance their life and support them to learn and maintain the life skills necessary to succeed in an inclusive society.

B. Procedures.

1. The provider will have applicable credentials or license for providing the educational service desired.

2. The individual will have a statement of need for the educational service in his/her plan of care.

3. If the individual receives this service funded through the Home and Community-Based Waiver, then the individual shall have the following documentation in their individual file:

a. That this service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142; and

b. That the individual has been deinstitutionalized from a nursing facility or intermediate care facility, at some prior time.

4. The provider will comply with Division and Department requirements for working with persons with disabilities.

R539-7-4. Personal Assistance Services.

A. Policy.

The Personal Assistance Services program provides adults with physical disabilities the maximum control to live as independently as possible in their choice of home, community and daily activities by providing funding to purchase assistant services. Personal Assistance

Services are provided in the recipient's own home or apartment, or community.

~~— B. Procedures.~~

~~— 1. Personal Assistance Services include all activities of daily living necessary to maintain well-being, personal appearance, comfort, safety and interactions within the community.~~

~~— 2. Each participant recruits and hires the person(s) to perform the needed attendant services.~~

~~— 3. The participant trains and supervises all activities performed by their employee(s) and has full responsibility for reimbursement, including payment of taxes.~~

~~— 4. The use of Personal Assistance Services Funds for any purpose other than to purchase or arrange for attendant services may result in suspension or discontinuation of Personal Assistance Services benefits.~~

~~— 5. Each participant will be reviewed annually by the Division specialist to determine satisfaction with existing services and to evaluate the continuing level of needed services.~~

~~— 6. Monthly benefit amounts shall be determined according to the number of hours of personal assistance provided through the Division not to exceed 84 hours per week unless approved by the Division Director.~~

~~**R539-7-5. Child Care Services.**~~

~~— A. Policy.~~

~~— The Division of Services for People with Disabilities may provide supplemental funding for child care for children with disabilities 12 years old and younger who are eligible for Division services and who are living with family; or funding for Latch key services supervision to~~

~~children with disabilities 13 years of age and older who are eligible for Division services, who are living with family, and whose parents are working or going to school. Latch Key services may be provided only when no other education or child care programs are available.~~

~~— B. Procedures.~~

~~— 1. Child care providers shall meet the child care licensing or certification requirements in accordance with R539-6-7, Licensing and Certification.~~

~~— 2. Parents are responsible to ensure that the basic fee for child care is paid to the provider of services. Child care providers receiving supplemental child care must write a plan of care, indicating the additional services the child will receive, which will be added to the child's Individual Family Support Plan in accordance with the Division's Policy #302.1, Individual Family Support Plan.~~

~~— 3. Latch Key services shall be provided under contract between the region and child care providers at the approved Division rate. Latch Key providers must write a plan of care, indicating the services the child will receive, which will be added to the child's Individual Family Support Plan in accordance with Division Policy #302.1, Individual Family Support Plan.~~

~~**KEY: disabled persons*, social services
March 18, 1996
Notice of Continuation December 18, 2002
62A-5-103]**~~



End of the Notices of 120-Day (Emergency) Rules Section

FIVE-YEAR NOTICES OF REVIEW AND STATEMENTS OF CONTINUATION

Within five years of an administrative rule's original enactment or last five-year review, the responsible agency is required to review the rule. This review is designed to remove obsolete rules from the *Utah Administrative Code*.

Upon reviewing a rule, an agency may: repeal the rule by filing a PROPOSED RULE; continue the rule as it is by filing a NOTICE OF REVIEW AND STATEMENT OF CONTINUATION (NOTICE); or amend the rule by filing a PROPOSED RULE and by filing a NOTICE. By filing a NOTICE, the agency indicates that the rule is still necessary.

NOTICES are not followed by the rule text. The rule text that is being continued may be found in the most recent edition of the *Utah Administrative Code*. The rule text may also be inspected at the agency or the Division of Administrative Rules. NOTICES are effective when filed. NOTICES are governed by *Utah Code* Section 63-46a-9 (1998).

Commerce, Occupational and Professional Licensing **R156-55d**

Utah Construction Trades Licensing Act Burglar Alarm Licensing Rules

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE No.: 28048
FILED: 06/28/2005, 13:47

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Title 58, Chapter 55, provides for the licensure of alarm companies and alarm company agents. Subsection 58-1-106(1)(a) provides that the Division may adopt and enforce rules to administer Title 58. Subsection 58-55-201(2)(a) provides that the Alarm System Security and Licensing Board's duties and responsibilities shall recommend appropriate rules to the Construction Services Commission. Subsection 58-55-103(1)(b)(i) provides that the Construction Services Commission shall, with the concurrence of the director, make reasonable rules to administer and enforce Chapter 55. This rule was enacted to clarify the provisions of Title 58, Chapter 55, with respect to alarm companies and alarm company agents.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: Since this rule was originally enacted in July 2000, it has been amended three times. In September 2000, the rule was amended and an August 23, 2000, rule hearing was conducted; however, no written comments were received at that time. In March 2001, an amendment to the rule was again filed; however, no written comments were received at that time. In June 2004, amendments were again filed and a July 7, 2004, rule hearing was conducted. A written E-mail comment, dated June 21, 2004, was received from Susan Allred of the Office of Legislative Research and General Counsel. Ms. Allred

suggested two wording changes to the proposed amendments which had been filed. As a result of Ms. Allred's comments, a change in proposed rule filing was made and the amendments were made effective on October 5, 2004.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule should be continued as it provides a mechanism to inform potential licensees of the requirements for licensure as allowed under statutory authority provided in Title 58, Chapter 55, with respect to alarm companies and alarm company agents. The rule should also be continued as it provides information to ensure applicants for licensure are adequately trained and meet minimum licensure requirements.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

COMMERCE
OCCUPATIONAL AND PROFESSIONAL LICENSING
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY UT 84111-2316, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Clyde Ormond at the above address, by phone at 801-530-6254, by FAX at 801-530-6511, or by Internet E-mail at cormond@utah.gov

AUTHORIZED BY: J. Craig Jackson, Director

EFFECTIVE: 06/28/2005



Community and Economic Development, Community Development, History **R212-11** Historic Preservation Tax Credit

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE No.: 28055
 FILED: 06/30/2005, 13:06

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Sections 59-7-609.5 and 59-10-108.5 allow for an historic preservation tax credit by the Utah State Tax Commission and provide for certain duties of the Division of State History and the State Historic Preservation Office. Section 9-8-205 provides that the Board of State History and the Division shall make policies and rules to direct the division director in the carrying out of his duties.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The purposes of this rule are: 1) to ensure an orderly process by the Division of State History and the State Historic Preservation Office; 2) to allow for appeal and judicial review of decisions, and 3) to ensure that all rehabilitation work on historic preservation tax credit projects meets the Secretary of the Interior's "Standards for Rehabilitation". Continuation of this rule is necessary for continued success of this program.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

COMMUNITY AND ECONOMIC DEVELOPMENT
 COMMUNITY DEVELOPMENT, HISTORY
 300 RIO GRANDE
 SALT LAKE CITY UT 84101-1182, or
 at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
 Alycia Aldrich at the above address, by phone at 801-533-3556, by FAX at 801-533-3503, or by Internet E-mail at AALDRICH@utah.gov

AUTHORIZED BY: Philip F. Notarianni, Director

EFFECTIVE: 06/30/2005



Human Services, Aging and Adult Services
R510-104
 Nutrition Programs for the Elderly (NPE)

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE No.: 28040
 FILED: 06/22/2005, 09:57

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Nutrition Programs for the Elderly is created under the authority of the Older Americans Act of 1965 as amended in 2000 which authorizes state units on aging to provide nutrition programs for the elderly via area agencies on aging. This rule describes the mechanisms for implementing that process. This rule is developed under authority of Section 62A-3-104.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule details how the nutrition program for the elderly is to be implemented by the local area agencies on aging, and insures that the activity is in compliance with the cited federal regulation. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HUMAN SERVICES
 AGING AND ADULT SERVICES
 Room 325
 120 N 200 W
 SALT LAKE CITY UT 84103-1500, or
 at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
 Mike Bednarek at the above address, by phone at 801-538-3922, by FAX at 801-538-4395, or by Internet E-mail at mjbednarek@utah.gov

AUTHORIZED BY: Lisa-Michele Church, Executive Director

EFFECTIVE: 06/22/2005



Human Services, Aging and Adult Services
R510-401
 Utah Caregiver Support Program

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE No.: 28039
 FILED: 06/22/2005, 09:55

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: The Utah Caregiver Support Program is created under authority of the Older Americans Act of 1965 as amended in 2000 which provides for federal funding to be passed through the state to Area Agencies on Aging to coordinate the delivery of support services to family caregivers of frail older individuals. This rule describes the requirements that are to be met to comply with the federal regulations. The rule is developed under authority of Section 62A-3-104.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule details how the caregiver support program is to be implemented by the local area agencies on aging, and insures that the activity is in compliance with the cited federal regulation. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HUMAN SERVICES
AGING AND ADULT SERVICES
Room 325
120 N 200 W
SALT LAKE CITY UT 84103-1500, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Mike Bednarek at the above address, by phone at 801-538-3922, by FAX at 801-538-4395, or by Internet E-mail at mjbednarek@utah.gov

AUTHORIZED BY: Lisa-Michele Church, Executive Director

EFFECTIVE: 06/22/2005



Natural Resources, Parks and Recreation

R651-409

Minimum Amounts of Liability Insurance Coverage for an Organized Practice or Sanctioned Race

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE No.: 28061
FILED: 07/01/2005, 08:41

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Section 63-11-17 gives the board of Utah State Parks and Recreation certain authority when requiring fees. Section 41-22-29 specifies that organized practices or sanctioned races shall have a continuously maintained insurance policy from a reliable insurance company that is authorized to do business in Utah.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: Any activity within Utah State Parks and Recreation owned or operated lands and parks that has to do with races and organized practices must be covered with proper insurance to protect the state owned areas. Such insurance shall be endorsed to add all persons providing services or who own lands affected by the activities conducted. Therefore, this rule should be continued to keep this insurance requirement in force.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

NATURAL RESOURCES
PARKS AND RECREATION
Room 116
1594 W NORTH TEMPLE
SALT LAKE CITY UT 84116-3154, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Dee Guess at the above address, by phone at 801-538-7320, by FAX at 801-537-3144, or by Internet E-mail at deeguess@utah.gov

AUTHORIZED BY: Mary Tullius, Director

EFFECTIVE: 07/01/2005



Natural Resources, Parks and Recreation

R651-634

Snowmobile User Fee - Non-Residents

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE No.: 28060
FILED: 07/01/2005, 08:26

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Section 63-11-17 allows the board of Utah State Parks and Recreation to charge fees. H.B. 51 (UT L 2004 Ch 314, effective 07/01/2004) and S.B. 14 (UT L 1999 Ch 1, effective 07/01/1999) state that the off-highway vehicle user annual fee shall be \$30.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: Any nonresident owning an off-highway vehicle, who operates or gives another person permission to operate the off-highway vehicle on any public land, trail, street, or highway in this state, shall pay an annual off-highway vehicle user fee as covered in Sections 41-22-35 and 63-11-17. As this practice is still going on, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

NATURAL RESOURCES
 PARKS AND RECREATION
 Room 116
 1594 W NORTH TEMPLE
 SALT LAKE CITY UT 84116-3154, or
 at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
 Dee Guess at the above address, by phone at 801-538-7320, by FAX at 801-537-3144, or by Internet E-mail at deeguess@utah.gov

AUTHORIZED BY: Mary Tullius, Director

EFFECTIVE: 07/01/2005



**Public Safety, Criminal Investigations
 and Technical Services, Criminal
 Identification
 R722-310
 Regulation of Bail Bond Recovery and
 Enforcement Agents**

**FIVE YEAR NOTICE OF REVIEW AND
 STATEMENT OF CONTINUATION**
 DAR FILE NO.: 28052
 FILED: 06/29/2005, 11:00

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: The Department of Public Safety is mandated under Section 53-11-101 with the responsibility of issuing license for persons wishing to work as bail bond recovery and enforcement officials in the State of Utah. This statute also mandates the Commissioner of Public Safety to make any rules necessary to administer this license.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: There is no language in statute which defines the appeal process, and this rule clearly define the process. Without the rule, the Commissioner of Public Safety would have to personally conduct each appeal. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

PUBLIC SAFETY
 CRIMINAL INVESTIGATIONS AND
 TECHNICAL SERVICES,
 CRIMINAL IDENTIFICATION
 CALVIN L RAMPTON COMPLEX
 4501 S 2700 W
 SALT LAKE CITY UT 84119-5994, or
 at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
 at the above address, by phone at , by FAX at , or by Internet E-mail at

AUTHORIZED BY: Ed McConkie, Bureau Chief

EFFECTIVE: 06/29/2005



**Public Safety, Criminal Investigations
 and Technical Services, Criminal
 Identification
 R722-330
 Licensing of Private Investigators**

**FIVE YEAR NOTICE OF REVIEW AND
 STATEMENT OF CONTINUATION**
 DAR FILE NO.: 28053
 FILED: 06/29/2005, 11:09

**NOTICE OF REVIEW AND
STATEMENT OF CONTINUATION**

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: The Department of Public Safety is mandated under Section 53-9-101 with the responsibility of issuing a license for persons wishing to work as private investigators in the state of Utah. This statute also mandates the Commissioner of Public Safety to make any rules necessary to administer this license.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule outlines the licensing and regulation standards of private investigators which is not in statute. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

PUBLIC SAFETY
CRIMINAL INVESTIGATIONS AND
TECHNICAL SERVICES,
CRIMINAL IDENTIFICATION
CALVIN L RAMPTON COMPLEX
4501 S 2700 W
SALT LAKE CITY UT 84119-5994, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Joyce Carter at the above address, by phone at 801-965-4576, by FAX at 801-965-4749, or by Internet E-mail at joycecarter@utah.gov

AUTHORIZED BY: Ed McConkie, Bureau Chief

EFFECTIVE: 06/29/2005



**Public Safety, Peace Officer Standards
and Training
R728-205
Council Resolution of Public Safety
Retirement Eligibility**

**FIVE YEAR NOTICE OF REVIEW AND
STATEMENT OF CONTINUATION**

DAR FILE No.: 28043
FILED: 06/27/2005, 16:00

**NOTICE OF REVIEW AND
STATEMENT OF CONTINUATION**

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: The enabling statute for this rule is Subsections 53-6-107(2), 49-14-201(4)(b), and 49-14-201(5) which gives Peace Officer Standards and Training (POST) Council the authority to approve special function officers for membership in the Utah Public Safety Retirement system.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The POST Council is the qualified group which evaluates the job responsibilities of a specific special function officer to see if they meet the requirements for eligibility as a member of the Utah Public Safety Retirement system. This rule provides for implementation of the mandate of Section 49-14-201 and Subsection 53-6-107(2). Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

PUBLIC SAFETY
PEACE OFFICER STANDARDS AND TRAINING
4525 S 2700 W
SALT LAKE CITY UT 84119, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Bonnie Braegger at the above address, by phone at 801-965-4099, by FAX at 801-965-4619, or by Internet E-mail at bbraegge@utah.gov

AUTHORIZED BY: Kenneth R. Wallentine, Administrative Counsel

EFFECTIVE: 06/27/2005



NOTICES OF FIVE-YEAR REVIEW EXTENSIONS

Rulewriting agencies are required by law to review each of their administrative rules within five years of the date of the rule's original enactment or the date of last review (*Utah Code* Section 63-46a-9 (1996)). If the agency finds that it will not meet the deadline for review of the rule (the five-year anniversary date), it may file an extension with the Division of Administrative Rules. The extension permits the agency to file the review up to 120 days beyond the anniversary date.

Agencies have filed extensions for the rules listed below. The "Extended Due Date" is 120 days after the anniversary date. The five-year review extension is governed by *Utah Code* Subsection 63-46a-9(4) and (5) (1996).

Environmental Quality

Air Quality

No. 28042 (filed 06/23/2005 at 3:06 p.m.): R307-205. Emission Standards: Fugitive Emissions and Fugitive Dust.

ENACTED OR LAST REVIEWED: 08/02/2000 (No. 23089, 5YR, filed 08/02/2000 at 12:33 p.m., published 09/01/2000).

EXTENDED DUE DATE: 11/30/2005

End of the Notices of Five-Year Review Extensions Section

NOTICES OF RULE EFFECTIVE DATES

These are the effective dates of PROPOSED RULES or CHANGES IN PROPOSED RULES published in earlier editions of the *Utah State Bulletin*. These effective dates are at least 31 days and not more than 120 days after the date the following rules were published.

Abbreviations

AMD = Amendment
CPR = Change in Proposed Rule
NEW = New Rule
R&R = Repeal and Reenact
REP = Repeal

Administrative Services

Finance

No. 27848 (AMD): R25-7. Travel-Related Reimbursements for State Employees.
Published: May 15, 2005
Effective: July 1, 2005

Commerce

Occupational and Professional Licensing

No. 27835 (AMD): R156-26a. Certified Public Accountant Licensing Act Rules.
Published: May 15, 2005
Effective: June 21, 2005

Environmental Quality

Water Quality

No. 27817 (AMD): R317-1-7. TMDLs.
Published: May 1, 2005
Effective: June 29, 2005

Health

Health Care Financing, Coverage and Reimbursement Policy

No. 27840 (AMD): R414-49. Dental Service.
Published: May 15, 2005
Effective: July 1, 2005

No. 27849 (AMD): R414-53. Eyeglasses Services.
Published: May 15, 2005
Effective: July 1, 2005

No. 27852 (AMD): R414-401-3. Assessment.
Published: May 15, 2005
Effective: July 1, 2005

No. 27851 (AMD): R414-504. Nursing Facility Payments.
Published: May 15, 2005
Effective: July 1, 2005

Epidemiology and Laboratory Services, Laboratory Improvement

No. 27850 (AMD): R444-14. Rule for the Certification of Environmental Laboratories.
Published: May 15, 2005
Effective: July 1, 2005

Transportation

Motor Carrier, Ports of Entry

No. 27790 (NEW): R912-6. Ports-of-Entry By-Pass Permit Provisions.
Published: April 15, 2005
Effective: June 27, 2005

Operations, Construction

No. 27846 (NEW): R916-4. Construction Manager/General Contractor Contracts.
Published: May 15, 2005
Effective: June 27, 2005

Workforce Services

Employment Development

No. 27830 (AMD): R986-700. Child Care Assistance.
Published: May 1, 2005
Effective: July 1, 2005

End of the Notices of Rule Effective Dates Section

RULES INDEX BY AGENCY (CODE NUMBER) AND BY KEYWORD (SUBJECT)

The *Rules Index* is a cumulative index that reflects all effective changes to Utah's administrative rules. The current *Index* lists changes made effective from January 2, 2005, including notices of effective date received through July 1, 2005, the effective dates of which are no later than July 15, 2005. The *Rules Index* is published in the *Utah State Bulletin* and in the annual *Index of Changes*. Nonsubstantive changes, while not published in the *Bulletin*, do become part of the *Utah Administrative Code (Code)* and are included in this *Index*, as well as 120-Day (Emergency) rules that do not become part of the *Code*. The rules are indexed by Agency (Code Number) and Keyword (Subject).

DAR NOTE: The index may contain inaccurate page number references. Also the index is incomplete in the sense that index entries for Changes in Proposed Rules (CPRs) are not preceded by entries for their parent Proposed Rules. Bulletin issue information and effective date information presented in the index are, to the best of our knowledge, complete and accurate. If you have any questions regarding the index and the information it contains, please contact Nancy Lancaster (801 538-3218), Mike Broschinsky (801 538-3003), or Kenneth A. Hansen (801 538-3777).

A copy of the *Rules Index* is available for public inspection at the Division of Administrative Rules (4120 State Office Building, Salt Lake City, UT), or may be viewed online at the Division's web site (<http://www.rules.utah.gov/>).

RULES INDEX - BY AGENCY (CODE NUMBER)

ABBREVIATIONS

AMD = Amendment	NSC = Nonsubstantive rule change
CPR = Change in proposed rule	REP = Repeal
EMR = Emergency rule (120 day)	R&R = Repeal and reenact
NEW = New rule	5YR = Five-Year Review
EXD = Expired	

CODE REFERENCE	TITLE	FILE NUMBER	ACTION	EFFECTIVE DATE	BULLETIN ISSUE/PAGE
Administrative Services					
<u>Child Welfare Parental Defense (Office of)</u>					
R19-1	Parental Defense Counsel Training	27518	NEW	05/13/2005	2004-22/9
R19-1	Parental Defense Training Standards	27518	CPR	05/13/2005	2005-2/94
<u>Facilities Construction and Management</u>					
R23-1	Procurement of Construction	27603	AMD	03/15/2005	2005-2/2
R23-2	Procurement of Architect-Engineer Services	27605	AMD	03/15/2005	2005-2/7
R23-3	Planning and Programming for Capital Projects	27615	AMD	03/15/2005	2005-2/9
R23-4	Suspension/Debarment and Contract Performance Review Committee	27610	AMD	03/15/2005	2005-2/10
R23-26	Dispute Resolution	27614	NEW	03/15/2005	2005-2/12
<u>Finance</u>					
R25-7	Travel-Related Reimbursements for State Employees	27848	AMD	07/01/2005	2005-10/7

CODE REFERENCE	TITLE	FILE NUMBER	ACTION	EFFECTIVE DATE	BULLETIN ISSUE/PAGE
<u>Fleet Operations</u>					
R27-1-2	Definitions	27546	AMD	01/10/2005	2004-23/3
R27-3-6	Application for Commute or Take Home Use	27599	NSC	02/01/2005	Not Printed
R27-4	Vehicle Replacement and Expansion of State Fleet	27543	AMD	01/10/2005	2004-23/5
R27-4-1	Authority	27594	NSC	02/01/2005	Not Printed
R27-6	Fuel Dispensing Program	27544	AMD	01/10/2005	2004-23/7
<u>Records Committee</u>					
R35-1a	State Records Committee Definitions	27621	NEW	03/08/2005	2005-2/17
R35-1a	State Records Committee Definitions	27700	NSC	04/01/2005	Not Printed
R35-2	Declining Appeal Hearings	27625	AMD	03/04/2005	2005-2/18
R35-3	Prehearing Conferences	27622	AMD	03/04/2005	2005-2/19
R35-4	Compliance with State Records Committee Decisions and Orders	27624	AMD	03/04/2005	2005-2/20
R35-5	Subpoenas Issued by the Records Committee	27623	AMD	03/04/2005	2005-2/21
R35-6	Expedited Hearing	27620	AMD	03/04/2005	2005-2/22
<u>Agriculture and Food</u>					
<u>Animal Industry</u>					
R58-1	Admission and Inspection of Livestock, Poultry, and Other Animals	27570	AMD	01/18/2005	2004-24/5
R58-1-7	Swine	27687	AMD	03/18/2005	2005-4/8
R58-2	Diseases, Inspections and Quarantines	27581	AMD	02/01/2005	2005-1/9
R58-7	Livestock Markets, Satellite Video Livestock Auction Market, Livestock Sales, Dealers, and Livestock Market Weighpersons	27688	5YR	02/01/2005	2005-4/47
R58-10	Meat and Poultry Inspection	27693	5YR	02/03/2005	2005-5/28
R58-17	Aquaculture and Aquatic Animal Health	27696	5YR	02/03/2005	2005-5/28
R58-21	Trichomoniasis	27694	5YR	02/03/2005	2005-5/29
R58-22	Equine Infectious Anemia (EIA)	27695	5YR	02/03/2005	2005-5/29
<u>Marketing and Conservation</u>					
R65-10	Agriculture Resource Development Loans (ARDL)	27787	5YR	03/31/2005	2005-8/56
<u>Plant Industry</u>					
R68-3	Utah Fertilizer Act Governing Fertilizers and Soil Amendments	27645	5YR	01/07/2005	2005-3/58
R68-20	Utah Organic Standards	27697	5YR	02/04/2005	2005-5/30
<u>Regulatory Services</u>					
R70-440	Egg Products Inspection	27514	NSC	01/01/2005	Not Printed
R70-440-2	Adopt by Reference	27628	AMD	02/15/2005	2005-2/23
R70-440-2	Adopt by Reference	27667	NSC	03/01/2005	Not Printed
R70-540-14	Exemptions	27569	AMD	03/18/2005	2004-24/7
R70-960-7	Registration Certificate Displayed	27523	NSC	01/01/2005	Not Printed
<u>Alcoholic Beverage Control</u>					
<u>Administration</u>					
R81-5-5	Advertising	27725	AMD	05/01/2005	2005-6/3
R81-5-14	Membership Fees and Monthly Dues	27726	AMD	05/01/2005	2005-6/4
R81-5-17	Visitor Cards	27727	AMD	05/01/2005	2005-6/5

RULES INDEX

CODE REFERENCE	TITLE	FILE NUMBER	ACTION	EFFECTIVE DATE	BULLETIN ISSUE/PAGE
Capitol Preservation Board (State)					
<u>Administration</u>					
R131-1	Procurement of Architectural and Engineering Services	27711	5YR	02/16/2005	2005-6/33
R131-2	Capitol Hill Facility Use	27712	5YR	02/16/2005	2005-6/33
R131-7	State Capitol Preservation Board Master Planning Policy	27713	5YR	02/16/2005	2005-6/34
R131-8	CPB Facilities and Grounds: Maintenance of Aesthetics	27631	NEW	03/03/2005	2005-2/24
R131-9	State Capitol Preservation Board Art Program and Policy	27632	NEW	03/03/2005	2005-2/26
Commerce					
<u>Administration</u>					
R151-1	Department of Commerce General Provisions	27633	NEW	02/15/2005	2005-2/29
R151-46b	Department of Commerce Administrative Procedures Act Rules	27636	AMD	02/15/2005	2005-2/32
<u>Occupational and Professional Licensing</u>					
R156-1	General Rules of the Division of Occupational and Professional Licensing	27499	NSC	01/01/2005	Not Printed
R156-17a	Pharmacy Practice Act Rules	27786	REP	05/17/2005	2005-8/2
R156-17b	Pharmacy Practice Act Rules	27529	CPR	05/17/2005	2005-8/43
R156-17b	Pharmacy Practice Act Rules	27529	NEW	05/17/2005	2004-23/20
R156-17b	Pharmacy Practice Act Rules	27529	CPR	05/17/2005	2005-4/31
R156-22	Professional Engineers and Professional Land Surveyors Licensing Act Rules	27698	AMD	04/04/2005	2005-5/2
R156-26a	Certified Public Accountant Licensing Act Rules	27835	AMD	06/21/2005	2005-10/12
R156-31b	Nurse Practice Act Rules	27600	AMD	02/17/2005	2005-2/36
R156-31b	Nurse Practice Act Rules	27714	NSC	04/01/2005	Not Printed
R156-38	Residence Lien Restriction and Lien Recovery Fund Rules	27752	5YR	03/15/2005	2005-7/75
R156-38b	State Construction Registry Rules	27734	NEW	04/18/2005	2005-6/6
R156-47b	Massage Therapy Practice Act Rules	27548	CPR	03/07/2005	2005-3/51
R156-47b	Massage Therapy Practice Act Rules	27548	AMD	03/07/2005	2004-24/7
R156-50	Private Probation Provider Licensing Act Rules	27435	CPR	01/18/2005	2004-24/58
R156-50	Private Probation Provider Licensing Act Rules	27435	AMD	01/18/2005	2004-20/12
R156-55d	Utah Construction Trades Licensing Act Burglar Alarm Licensing Rules	28048	5YR	06/28/2005	2005-14/98
R156-56	Utah Uniform Building Standard Act Rules	27489	AMD	01/01/2005	2004-21/6
R156-56-704	Statewide Amendments to the IBC	27490	AMD	01/01/2005	2004-21/11
R156-60c	Professional Counselor Licensing Act Rules	27749	5YR	03/14/2005	2005-7/75
R156-61-502	Unprofessional Conduct	27538	AMD	01/04/2005	2004-23/40
R156-71-202	Naturopathic Physician Formulary	27533	AMD	01/04/2005	2004-23/41
<u>Real Estate</u>					
R162-2-2	Licensing Procedure	27720	NSC	04/01/2005	Not Printed
R162-102-1	Application	27797	AMD	05/25/2005	2005-8/12
R162-107	Unprofessional Conduct	27788	AMD	05/25/2005	2005-8/14
<u>Securities</u>					
R164-2	Investment Adviser - Unlawful Acts	27732	5YR	02/28/2005	2005-6/34
R164-2-1	Investment Adviser Performance-Based Compensation Contracts	27735	NSC	04/01/2005	Not Printed

CODE REFERENCE	TITLE	FILE NUMBER	ACTION	EFFECTIVE DATE	BULLETIN ISSUE/PAGE
R164-9-1	Registration by Coordination	27777	EMR	03/25/2005	2005-8/53

Community and Economic Development

Community Development, Community Services

R202-202-202	Opening and Closing Dates for HEAT Program	27418	AMD	01/12/2005	2004-19/24
R202-203-324	Income Deductions	27421	AMD	01/12/2005	2004-19/25
R202-203-328	Self-Employment Income	27419	AMD	01/12/2005	2004-19/26
R202-207-702	Records Management	27420	AMD	01/12/2005	2004-19/27

Community Development, History

R212-11	Historic Preservation Tax Credit	28055	5YR	06/30/2005	2005-14/99
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Education

Administration

R277-400	School Emergency Response Plans	27539	NSC	01/01/2005	Not Printed
R277-407	School Fees	27798	AMD	05/19/2005	2005-8/15
R277-410	Accreditation of Schools	27705	AMD	04/01/2005	2005-5/8
R277-411	Elementary School Accreditation	27706	AMD	04/01/2005	2005-5/10
R277-412	Junior High and Middle School Accreditation	27707	AMD	04/01/2005	2005-5/13
R277-413	Accreditation of Secondary Schools, Alternative or Special Purpose Schools	27708	AMD	04/01/2005	2005-5/16
R277-422	State Supported Voted Leeway, Local Board-Approved Leeway and Local Board Leeway for Reading Improvement Programs	27702	NSC	03/01/2005	Not Printed
R277-437	Student Enrollment Options	27799	AMD	05/19/2005	2005-8/17
R277-438	Dual Enrollment	27800	AMD	05/19/2005	2005-8/19
R277-459	Teachers' Supplies and Materials Appropriation	28075	5YR	07/06/2005	Not Printed
R277-464	Highly Impacted Schools	28076	5YR	07/06/2005	Not Printed
R277-473	Testing Procedures	27547	AMD	01/04/2005	2004-23/43
R277-473	Testing Procedures	27872	5YR	05/09/2005	2005-11/90
R277-501	Educator Licensing Renewal, Highly Qualified and Timelines	27722	5YR	02/23/2005	2005-6/35
R277-520	Appropriate Licensing and Assignment of Teachers	28077	5YR	07/06/2005	Not Printed
R277-602	Special Needs Scholarships - Funding and Procedures	28026	EMR	06/14/2005	2005-13/47
R277-705-6	Utah Basic Skills Competency Testing Requirements and Procedures	27710	AMD	04/01/2005	2005-5/19
R277-713	Concurrent Enrollment of High School Students in College Courses	27662	AMD	03/21/2005	2005-4/14
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R710-9-6	Amendments and Additions	27655	AMD	03/04/2005	2005-3/47
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ABBREVIATIONS

AMD = Amendment	NSC = Nonsubstantive rule change
CPR = Change in proposed rule	REP = Repeal
EMR = Emergency rule (120 day)	R&R = Repeal and reenact
NEW = New rule	5YR = Five-Year Review
EXD = Expired	

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	27908	R309-115	5YR	05/16/2005	2005-11/92
	27909	R309-150	5YR	05/16/2005	2005-11/92
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	27781	R309-405	NSC	05/16/2005	Not Printed
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	27604	R850-26	NEW	04/01/2005	2005-2/84
	27601	R850-27	NEW	04/01/2005	2005-2/86
	27811	R850-50	AMD	06/01/2005	2005-9/49
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	28079	R307-320	5YR	07/07/2005	Not Printed
	27767	R307-421	NEW	07/07/2005	2005-7/28
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<u>air travel</u> Administrative Services, Finance	27848	R25-7	AMD	07/01/2005	2005-10/7
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	27617	R309-305	NSC	02/01/2005	Not Printed
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	27828	R865-19S-68	AMD	07/01/2005	2005-9/57
	27831	R865-19S-71	AMD	07/01/2005	2005-9/58
	27832	R865-19S-85	AMD	07/01/2005	2005-9/59
	27834	R865-19S-101	AMD	07/01/2005	2005-9/62
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<u>teachers</u>					
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	27302	R746-360-9	CPR	01/04/2005	2004-23/54
	27302	R746-360-9	AMD	01/04/2005	2004-15/59
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	27789	R994-204	5YR	04/01/2005	2005-8/59
	27791	R994-205	5YR	04/01/2005	2005-8/59
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	27729	R994-403	NSC	04/01/2005	Not Printed
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	27392	R655-4	AMD	01/12/2005	2004-18/30
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